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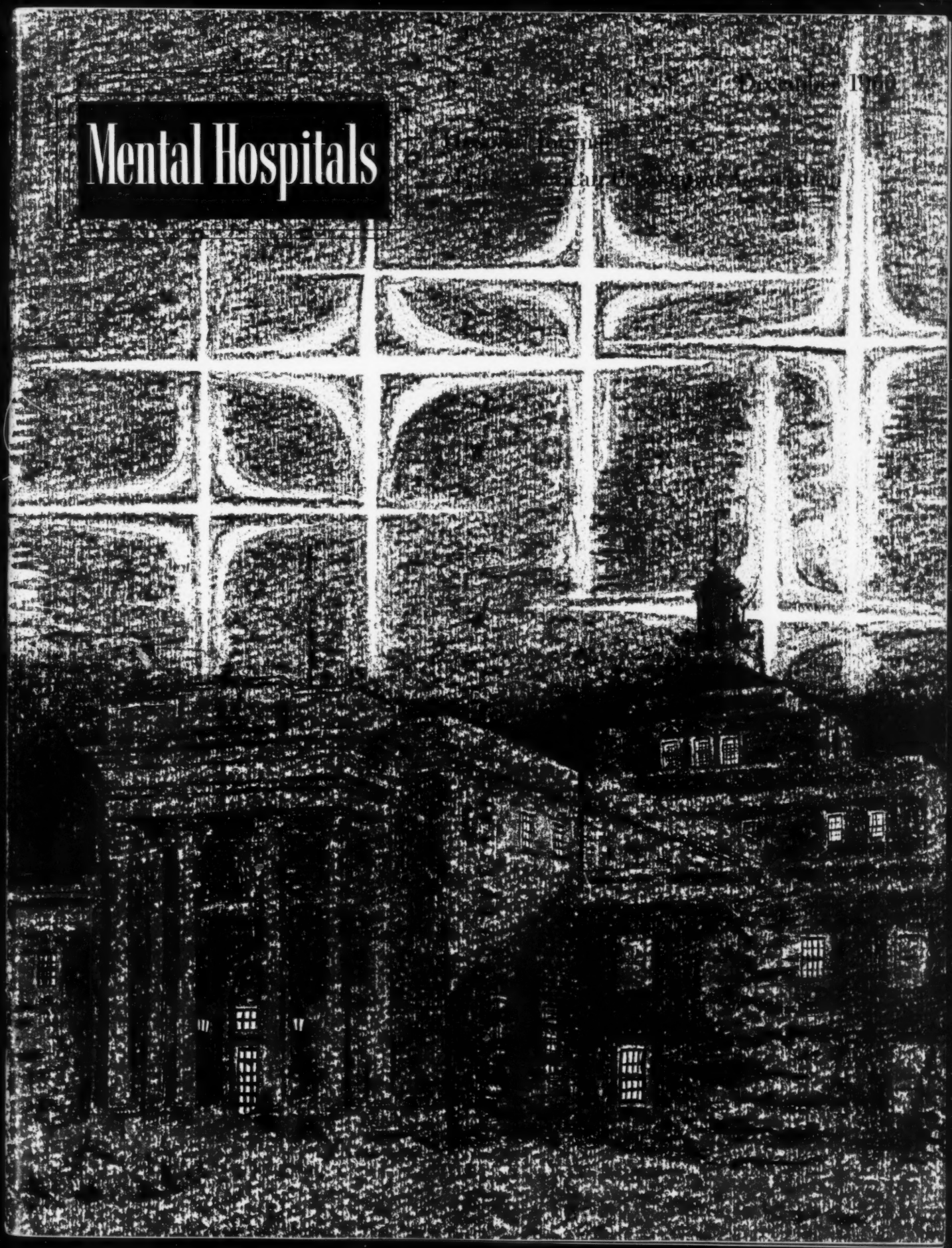

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*Diamond, O. K.: New York J. Med. **59**:1792, 1959.

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1. Ayd, F. J.: Clin. Med. 6:387, 1959. 2. May, R. H.: Am. J. Psychiat. 116:360, 1959. 3. Brock, S. (Moderator): Bull. New York Acad. Med. 32:202, 1956.

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Mental Hospitals

Hospital Journal of the

AMERICAN PSYCHIATRIC ASSOCIATION

Contents, December 1960

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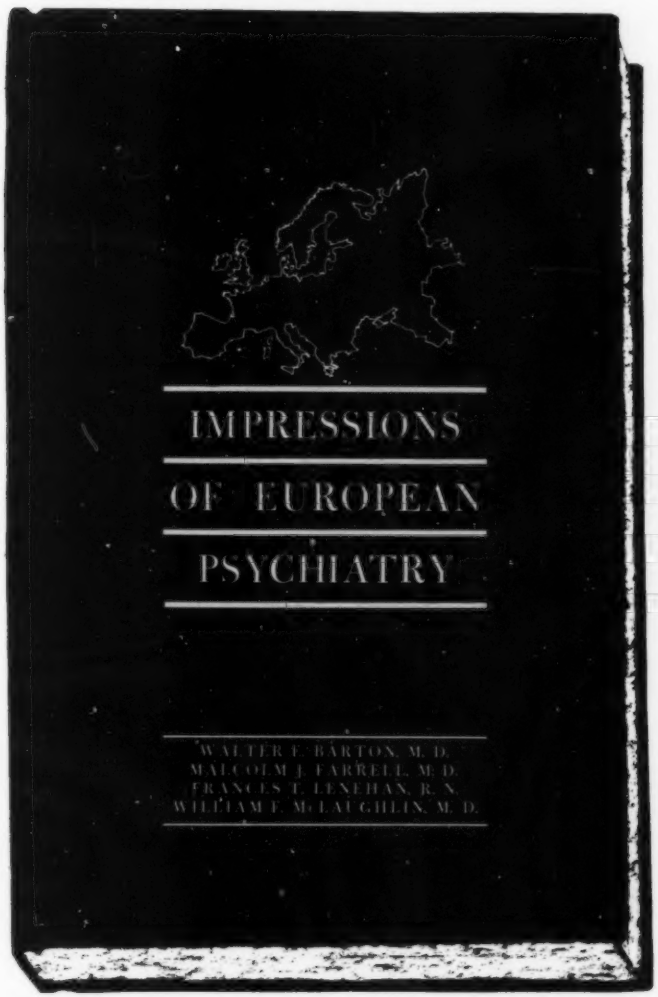

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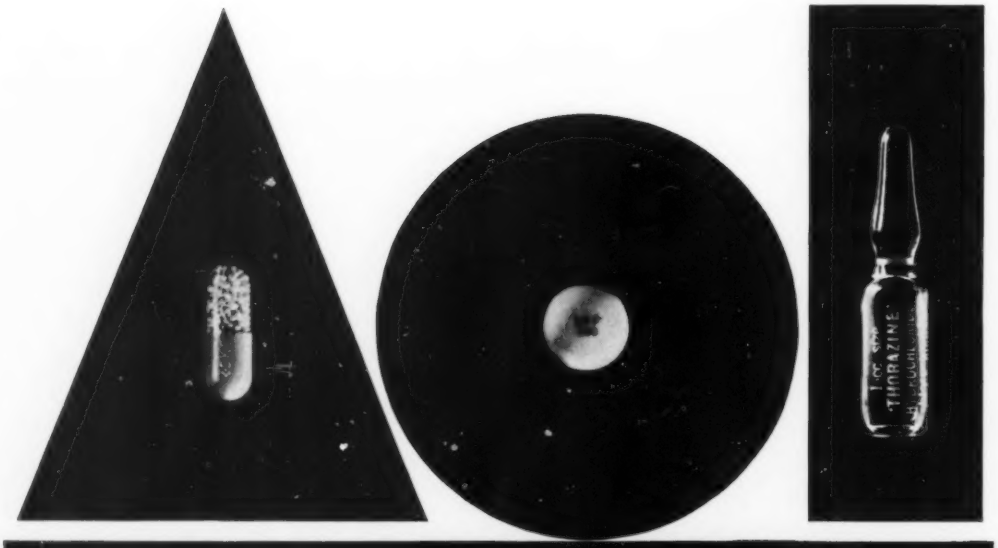

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REHABILITATION OF THE MENTALLY ILL

By C. A. ROBERTS, M.D.
Medical Superintendent, Verdun Protestant Hospital
Assistant Professor of Psychiatry, McGill University
Montreal, P.Q., Canada

PSYCHIATRY HAS APPARENTLY BEEN CHARACTERIZED by a failure of communciation. No other field of medicine has so quickly introduced new terms and discarded them in favor of others. These failures of communication and the too rapid introduction of new terminology probably account for the recurrent waves of enthusiasm in psychiatry and their subsequent abatement as those responsible for leadership in each successive period pass out of the picture. Many people have reviewed the history of mental hospital programs and it seems reasonable to conclude that the failure to pass on from one generation to the next those things that have proved useful is due to our unwillingness or inability to describe in readily understandable language and in an adequate theoretical framework the activities which have been beneficial in the treatment of psychiatrically ill patients. The two great status words of the present period would appear to be "rehabilitation" and "research." The purpose of our present discussion is to clarify our thinking in the field of rehabilitation.

As a first step, I propose to give my own working definition of the word "rehabilitation." This definition is not original but has been drawn from a number of sources. Some years ago, Dr. Howard Rusk stated that rehabilitation was the third phase of medicine, but this idea has been rapidly discarded as it has become apparent that rehabilitation is in fact the *total* treatment program for any particular patient. I have found it useful to think of rehabilitation as *those processes which enable a patient to obtain the maximum social and personal function compatible with the personal, social, and community resources available to him.* This definition consists essentially of three parts—the rehabilitation (treatment) processes, the maximum personal and social function, and the community and personal (deficits due to illness and total personal assets) resources available to the patient.

When does rehabilitation commence? This question is generally answered by the statement that rehabilitation should commence as soon as the patient becomes ill. A further inquiry as to what this means is usually greeted by a profound silence. It seems difficult to gain acceptance for the idea that rehabilitation commencing at the time a patient becomes ill is really a matter of an essential attitude which all of those responsible for treatment must have, and which the patient himself must assimilate from the total treatment team. *The patient must feel from the beginning that the whole purpose of all the resources brought to bear on his illness is to see that he returns to the community with maximum personal and social function.*

Traditionally, physicians have been concerned with medical diagnoses and with the treatment of the specific conditions diagnosed. A positive attitude toward rehabilitation requires the physician to be concerned with total assessment rather than purely medical diagnosis. That is to say, the physician at the time of his initial examination must make a complete medical, vocational, and social assessment of the patient. All treatment must be planned in terms of the initial and subsequent assessments. The physician must be concerned with the specific medical treatment indicated and with all of the general supportive measures which are designed to improve the patient's vocational and social function. It is helpful to keep in mind that a comprehensive rehabilitation program must include, at least as an available resource, academic and vocational training.

ORGANIZATION FOR REHABILITATION

While it is useful to think of rehabilitation activities on the basis of existing organizations, it should be borne in mind that the treatment of a patient should be a continuum, and that many aspects of our present organizations are not the most desirable, whether one is concerned with specific psychiatric treatment, rehabilitation, community care, or some other particular type of activity. In order to focus attention on rehabilitation, it is useful to consider the activities which take place in a hospital, in an outpatient department, in a community clinic, or in an aftercare program. The ideal we should strive for is a community mental health center as described in

Ed. Note: This article is based on a paper which the author presented at the Ontario Mental Health Services Institute on Rehabilitation, June 1, 1960, in Toronto. Much interesting discussion material which Dr. Roberts included in his original paper has had to be omitted for lack of space.

the Third and Fifth Reports of the Expert Committee on Mental Health of the World Health Organization. In this concept of a community mental health service, each region or area would have its own mental health service based on inpatient beds but being as concerned with preadmission treatment, post-discharge follow-up, rehabilitation, and other aspects of the program as with inpatient care. Such a service would be readily available to all the people it is designed to serve and many of our present problems of communication, distance, and difficulty in assuring continuity of personnel and services would not exist. While we must continue to work with the services as we have them, and while we must do everything possible to see that our patients function at the maximum level as a result of our treatment, we should not fail to look forward to the time when our mental health service will be organized on a patient-care basis rather than on administrative lines devoted to inpatient care, outpatient care, and similar lines of authority and communication.

It is my impression that a rehabilitation program has the same characteristics and must function on the same basic principles whether it deals with inpatients or ambulatory patients, and that the services rendered differ quantitatively rather than qualitatively. In this respect, psychiatry is probably different from many other specialties as it is apparent that the type of treatment provided for a psychiatric patient is determined more by the patient's dependency needs than by his psychiatric diagnosis, whereas in specialties such as surgery it is more frequently the medical diagnosis and the need for specific hospital procedures which determine the type of treatment provided.

We are all well aware that many schizophrenics are functioning at some satisfactory level in the community, whereas others, who would be considered less sick on a straight psychiatric assessment, require hospital care. Schizophrenics are not usually admitted to the hospital because they are diagnosed as suffering from this condition but because along with this condition they are unable to function in a socially acceptable manner. Our objective in treatment is not to make sure that a schizophrenic no longer has delusions or hallucinations, but rather to be sure that his behavior will be socially acceptable. Many of our so-called cured schizophrenics still have delusions but they have learned not to act on the basis of these and can function in an acceptable manner.

COMMUNITY ATTITUDES

If we are to provide programs designed to develop the maximum function attainable with the patients' total resources, we must also consider the community's attitude and the community's assessment of maximum function. If one considers the mores of the average North American community, one quickly observes that a "normal" day consists of three eight-hour periods—eight hours of work, eight hours of recreation, and eight hours of rest. While many individuals vary from this community average, we can be sure that anyone who deviates substantially is all too often critically assessed by his friends and associates. I regularly ask groups of people, "Who in our community does not work?" The two answers I always receive are, "Those who are sick," and "Those who are lazy." It is strange that these two answers are almost always given, even though in the Montreal area there is continuing serious unemployment. Even after this matter of unemployment is raised, it is not uncommon to find a group replying, "They could work if they wanted to." This community judgment seems to apply to the rich as well as to the poor, to housewives, to students, and to breadwinners. We have certainly found that patients will not do well on discharge unless they are capable of working according to the mores of their particular group. A school-child must study, a single girl, if not employed, must help with the household chores, a housewife must do her housework, and so on.

MOTIVATING FACTORS

The development of an inpatient program which can bring a person to maximum work or vocational function is handicapped by several community attitudes. Just as the community says the sick do not work, so it also says, "The sick are cared for in a hospital," and "When I am sick and in a hospital I do not work." It thus becomes essential in the development of a full rehabilitation program to consider those things which motivate a person in the community to work. It is interesting to discuss these motivating factors with different groups of people. I find that student nurses almost always answer in the following order: "I work to gain personal satisfaction," "I work so that I can help others," and "I work for money." On the other hand, male attendants-in-training almost always reverse the order: they work for money, to help others, and for personal satisfaction.

A further breakdown of these motivating factors shows us that when people say "I work for personal satisfaction," they really mean they would like to do something which they enjoy doing and which other people regard as important. When they say that they work to help others, we frequently find that their families or associates have been engaged in the service professions, and that, as a result, they are really looking for an activity where they will be associated with such individuals, who will give them recognition for the services they perform. The last factor, that of earning a living, is a highly variable one, which has become increasingly more difficult to assess in our North American society. As more and more work situations are developed in which it is not easy to find personal satisfaction and community recognition for the work performed, a greater emphasis has been placed on the material reward which can be obtained from higher wages. While all of the above are highly complex and difficult to evaluate, they are of the utmost importance in planning the rehabilitation of psychiatric patients.

It is quite apparent that the rehabilitation of a well educated individual with a good employment record and sound vocational training is not difficult at all. Such a person, subsequent to an acute depression or other episode of illness, is generally quite capable of self-rehabilitation.

There are also women patients who are married and whose vocation in life is to be a housewife. Generally speaking, they do not require vocational training and, if their illness is controlled to the point where they can get along well with their family, can rest well, and can find satisfactory social contacts, they return to their normal activity and do reasonably well, at least between the episodes of illness.

There is an increasingly large number of geriatric patients who can get along well in the community if they are well oriented, able to rest properly, and capable of filling the "elder statesman" role. For example, we have found it possible to place some elderly women in the community by finding suitable homes in which they can assume the normal grandmother role.

Finally, there are those patients who constitute the hard core of our rehabilitation problem. These are patients with an incomplete education and a very poor vocational record. They fall into many diagnostic categories, but prominent amongst them are psychiatrically ill patients who are also mentally retarded; schizophrenics who had their first breakdown before they quite finished their schooling; and the psychopaths (or sociopaths) who did not succeed in applying themselves for a sufficient length of time to gain a basic education. The rehabilitation of these groups is as much a matter of education as it is of psychiatry, but that is not to say that rehabilitation should be carried out apart from psychiatric services, since these people certainly require treatment in a psychiatrically oriented facility. The problems of rehabilitation for these groups are essentially different.

The psychiatrically ill person who is also mentally defective frequently requires training, assessment, and special placement to enable him to obtain a position in society compatible with his level of intelligence and in which he will not be either subject to too much demand or placed in a position so inferior that it fails to give him satisfaction.

The schizophrenic, on the other hand, has suffered basically from a failure of maturation, particularly in the area of interpersonal relationships. His rehabilitation is primarily a matter of conditioning or "treatment" so that he can at least function interpersonally at a socially acceptable level. At the same time he must be given sufficient academic and vocational training to enable him to establish a satisfactory place for himself in society.

The third group, namely the psychopaths, are a much more difficult problem. Intellectually they are seldom handicapped but the normal motivation for socially acceptable function seems to be lacking in them. By the time we see these patients in our adult services, they have generally learned that there are easier ways than working to obtain a certain standard of living, and that there are ways quite apart from making a useful social contribution, to gain a form of recognition. For these individuals, we find that time is of the essence. They must be placed in an environment where the causes of their illness will be understood, and where they will be treated fairly and consistently. Since they fluctuate between the ability to accept responsibility and the need to have it withdrawn, constant adaptation to this changeability is vital.

Thus a comprehensive rehabilitation program must rest on the following principles:

1. A complete assessment of the medical, psychiatric, vocational, and social potentialities of each individual patient.
2. Adequate specific and general treatment for the psychiatric disability diagnosed.
3. Academic and vocational training which will enable the person to contribute in a socially acceptable way to the society in which he lives.
4. Vocational and social placement determined in accordance with the patient's medical, vocational, and social handicaps or potentialities.

To carry out such a program all of the diagnostic services must be conscious of the need for complete assessment rather than concerned only with the specific psychiatric disability which presents itself. Secondly, the treatment service must be supported by a program designed to enable a patient to function according to the mores of the community, with particular concern for work, recreation, and rest. Thirdly, for adequate placement in the community, a series of facilities must be developed ranging from residential rehabilitation centers through sheltered workshops and foster-homes.

DRUGS AND PSYCHOTHERAPY

I have carefully avoided a discussion of psychological and pharmacological support for the patient during rehabilitation. This is because of a fundamental belief that these are only a part of a comprehensive treatment program. If they are taken out of perspective, there is too much tendency to feel that drugs and psychotherapy alone can be sufficient in the treatment of all our patients. It is true that a considerable number of patients can function adequately on the basis of one or both of these methods of treatment, and that patients undergoing the process of rehabilitation must, of course, receive the appropriate drugs and the required psychotherapy. But such therapies alone do not constitute a comprehensive rehabilitation program. We must always remember that a very anxious woman can get along quite well at home provided she does not disturb her family's normal essential activities. On the other hand, an anxious woman who interferes with her husband's normal rest and prevents him from earning a living will very soon find herself in the hospital. Conversely, a man who can earn a living will be able to function in the community with much greater success than can the man who does not work to support his family. The judgment of the community regarding the state of health of our patients will always be based on their ability to fill a useful and contributory role in society, to use their leisure time profitably, and to rest during the expected periods. A person who can function on this basis is well in the eyes of the community. Regardless of how well we may say an 18 year old schizophrenic girl is, she will be sick in the eyes of her mother if she cannot be a mother's helper. And if we insist she is well, then her mother will say, as I have so often heard, "Doctor, if she is not sick then she must be lazy."

The following items appear to be all-important if our programs for the rehabilitation of patients are to be effective:

1. A change in the traditional attitude regarding the role of the psychiatrist. As in other fields of medicine, the concept of "cure" seems to be detrimental rather than helpful. We must see psychiatric illnesses as part of the life history of the individual and we must see adequate treatment as being concerned, not only with signs and symptoms, but with the ability to function as a useful contributing member of society, self-supporting and able to exist harmoniously with family and with society at large.

2. Psychiatric treatment *per se* is only one of the resources available to our patients whether they be treated as inpatients or outpatients. The improvement of communication between our services and other community services which can help people who are unable to function effectively is essential.

3. While the basic attitudes of the community are in need of change, more effective change may result from involvement in activities other than the traditional public education ones. The community should be involved in the further development and expansion of day-care centers, residential centers, social rehabilitation centers, vocational training centers, and sheltered workshops. As the community becomes involved in these programs, understanding of the needs of patients with psychiatric illnesses will increase and attitudes toward such patients will undoubtedly change. Concurrent with this change one might reasonably anticipate improved attitudes in the matters of employment, rehabilitation allowances, and other community benefits which must be established if the patient is to feel secure and remain well.

4. Lastly, it does appear that the psychiatric patient has one great need regardless of our team approach or the resources which we may develop to assist with his rehabilitation, namely, the need for a relationship with *one person* to whom he can turn with confidence and with the assurance of understanding and acceptance. •

THE ANATOMY OF DEDICATION

By DR. WHATSISNAME

WE TOSS AROUND that word "dedication." But no one seems to have listed the ingredients. We know what dedication is *not*. A dedicated person need not necessarily be intelligent, efficient, or competent. Nor does dedication imply intransigence. So long as he moves toward the goal, the dedicated person is willing to compromise on means.

In the hospital, the dedicated employee is proud of his work, and wants to be assured that it is an indispensable part of the whole hospital program. Self-respect is essential to dedication—and it will pay the superintendent and personnel people to think of how an employee's self-respect may be maintained. This need not mean any effort to aggrandize the employee since self-denial is also a part of dedication. The problem is to make him enjoy his own self-denial—his not watching the clock, for instance, or his doing things beyond the call of duty. Dedication requires patience plus persistence. Short-term goals are rare in our work, and the dedicated employee must be shown how to remain undiscouraged at the slow pace of progress.

A distinguishing feature of the dedicated staff member is his willingness to yield on procedures and fight on principles. Even Abraham Lincoln had to compromise with petty politicians—or he would never have been nominated. Every hospital official says that he will never do anything to hurt patients—and this is the touchstone of compromise. But every man must draw that line for himself. He who draws it so close that he never yields is not dedicated; he is pigheaded. And the one who draws the line so far away that he is always quick to compromise is not dedicated either: he is an opportunist.

The dedicated man sets his sights high. He aims, perhaps, to hit the moon: this has been done and can be done again. He does not set his sights at the north star. Fatuous idealism will drain all his energies and devotion into nothingness.

He eats up his work as he eats a good meal: with fine appetite and unmistakable relish. The essence of dedication is not abstract virtue: rather, it is unfailing zest. The superintendent who wants a dedicated staff will first select those with zest—for this he cannot give them. For the other qualities, the road-map is there if he will but follow it.

Religion, Psychiatry, and the Geriatric Patient

By EDGAR B. JACKSON, M.D.
Mental Health Institute
Independence, Iowa

Ed. Note: This is a synopsis of a paper presented at the Annual Conference of Pastors in November 1959, at the Osawatomie State Hospital, Kansas, where the author was director of the Geriatric Treatment and Research Unit.

IT WOULD BE DIFFICULT to overstress the importance of the close relationship which exists between psychiatry and religion. Frequently both deal with the same problems and aim for the same goals. Psychiatry is principally concerned with patterns of behavior and must of necessity take moral issues into account. Religion seeks to stimulate changes in behavior patterns and offers motives and rewards, mainly from an eschatological frame of reference. Through the services of psychiatry we are better able to see and evaluate the motivations basic to behavior patterns. Religion is concerned with our behavior principally as it affects those with whom we come into contact, and we are exhorted to love our neighbors as ourselves in all our interpersonal relationships. Psychiatry is also concerned with interpersonal relationships and our adjustment to and moulding by society.

There is no area in psychiatry where religion is more important than in dealing with the problems associated with the process of aging. Jung clearly recognized this when he stated: "Among all my patients in the second half of life there has not been one whose problem in the last resort was not of finding a religious outlook on life. It is safe to say that everyone of them fell ill because he had lost that which the living religions . . . have given to their followers and none of them has really been healed who did not regain his religious outlook on life."[1]

As people grow older they become more concerned with the problem of finding a meaning for their life. As they look back over the years, and unfortunately many of them have little else to do, they raise the questions of "why" and "wherefore." They become more concerned with the problems of existence and of their individual relationship to the cosmos. Death suddenly becomes a reality which has to be considered as an imminent event. Anxiety is one of the commonest presentments which we see in the geriatric patient and this is what we might expect if we agree with Paul Tillich, the theologian, when he states that anxiety is the emotional response which follows a realization of the threat of nonbeing or meaninglessness in one's existence.

[1]*Jung, Carl G.: Modern Man in Search of a Soul, New York, Harcourt, Brace, 1933.*

PROBLEMS OF THE GERIATRIC PATIENT

Loss of Memory: Loss of memory constitutes one of the biggest problems that the aging individual has to face. In the past it was widely assumed that developing organicity accounted for the complete clinical picture of failing ability to recall, but this is by no means the case. Many psychological factors play an important role here, and we must consider not only what motivation the patient has to recall events, but also what significance the content of the forgotten material has in the light of the patient's personality and psychological needs.

Narcissistic Losses: The loss of love objects is of extreme importance to the geriatric patient, and the manner in which he deals with this problem will, in a large measure, determine the level of emotional adjustment to which he will gravitate. One of the first losses of this nature occurs in females in the pregeriatric age period known as the menopause. This can be experienced as a severe narcissistic loss to the patient because it means her loss of function as a woman. The appreciation of this fact is one of the basic causes for the development of severe depressive reactions at this time. It is unfortunate that shortly after this event occurs, many mothers receive their second severe narcissistic loss—namely the loss of the children from the parental home. To the mother, who has lived and planned all her life for the welfare of her family, this is a serious blow. While the children were at home, mother was a very significant person. She had a distinct sense of being needed and being useful. In many cases, when the children leave home, this sense of usefulness leaves with them. The male patient, at about this same period in life, is faced with gradually decreasing sexual potency, and this can be a severe narcissistic loss for him.

Loss of Self-Esteem: Low self-esteem is at the root of many of the psychological changes seen in geriatric pa-

Request to Readers

Personal conversations with our authors during meetings often reveal the fact that they have received many letters of comment, congratulations, or criticism on their published paper. Because of the wide personal acquaintance among those who work in hospital psychiatry, such correspondence usually goes directly to the individual rather than being sent through MENTAL HOSPITALS.

It would be of great assistance to the Editor and his staff if the writers or the recipients of such letters would send us a copy. Not only would it help guide us in our selection of material for publication, but, in many cases, permission to publish the comments would help make MENTAL HOSPITALS a real forum for the discussion of current issues. Your cooperation would be appreciated.

tients. Our whole culture is based on the idea that our usefulness as individuals is closely related to our productivity. Our sense of values is closely related to materialistic standards. Thus, the geriatric patient who feels that he has lost his usefulness experiences a rapid fall in his self-esteem.

REACTIONS IN THE GERIATRIC PATIENT

Suspicion and Paranoid Features: A common psychotic reaction seen in the geriatric patient is associated with severe disorganization of the personality and the development of suspiciousness and paranoid features. When this picture is seen, it is almost certain that the psychopathology has been produced as a reaction against extremely low self-esteem. In fact, the self-esteem appears to be in recriprocal relationship to the severity of the paranoid ideation. With the gradual awareness of his increasing incapacity to perform as he once did, the geriatric patient is inclined to project his own shortcomings onto others.

Denial: The geriatric patient makes extensive use of the primitive mechanism of denial. When problems arise which are too stressful and difficult for the patient to deal with, he attempts to solve the problems by denying that they exist. When he becomes concerned with the advancing years, illness, and possible death he uses every means at his disposal to deny the present situation.

Depression and Loss of Interest: In younger patients, depressive reactions are frequently associated with the inability to express hostility. This type of reaction is seen with much less frequency in the geriatric patient, who generally presents a milder form of depression often associated with a recent narcissistic loss.

Hypochondriasis: It is not unusual to find geriatric patients presenting numerous somatic complaints which, upon investigation, prove to have no demonstrable organic basis. Generally, the production of such symptoms is a last resort and they may serve two useful purposes. In the first place a physical complaint is an excellent method of denying emotional disturbance and the symptom is thus a protective device to safeguard the patient's failing self-esteem. The development of such symptoms may also be evidence that the patient has failed in his attempt to win the love, respect, and continued appreciation that he so desperately craves. When he becomes convinced of his failure to accomplish this, he attempts by illness to coerce his friends into giving him love and attention.

COOPERATIVE TREATMENT POSSIBILITIES

Geriatric individuals have certain problems, fears, and needs, and in many instances these can be resolved by the pastor and the psychiatrist working in cooperation. During the patient's hospitalization the psychiatrist has been able to point him in the direction of recovery and has aided him with his first faltering steps. Once the patient is in the community again, it is of extreme importance that he continue on this path of recovery, and his pastor is well equipped to help him.

As we have already seen, the patient will be concerned with the fear of death, although he may use devious methods of denying it. This fear of death may be one of the causes of the free-floating anxiety often seen in the geriatric patient, and may frequently be expressed by severe insomnia. The patient is afraid to go to sleep because he realizes the possibility that he may never awaken again.

The pastor must always be on the lookout for this fear of death, disguised though it may be. The more the patient denies it, the more he wants someone to break through his shell and discuss the problem with him. If the pastor himself feels comfortable with the thought of death, his sense of security will be communicated to the patient. He should never be afraid to discuss death with the individual, and should explain what it means within his particular theological frame of reference. This is often comforting to the patient. Reluctance on the part of the pastor to discuss death may be a further indication to the patient that it is something about which he should feel anxious.

The patient will frequently approach the pastor with evidence of severe guilt feelings. If the guilt is on the level of consciousness, the patient may receive help from consideration and application of some means of expiation and atonement. In such cases the services of the pastor are invaluable. However, the patient may feel guilty and unworthy and yet be unable to give any clue as to why he feels this way. In such cases, directions toward a method of atonement will be of no avail, and once the pastor recognizes such signs he should immediately refer the patient to a psychiatrist.

Guilt feelings may have another import for the patient, as a recent case of mine will demonstrate. This patient came to me because he felt he was doomed, and bound for perdition, and that nothing could ever be done to change the verdict. He was able to verbalize his feelings of guilt, but he was unable to give an explanation. Repeated interviews with the patient under the influence of sodium amytal sedation gave no indication of what the hidden cause of his guilt feelings might be. Observa-

tions by the late Karen Horney[1] have suggested that guilt feelings can be the result of a fear of disapproval. She pointed out that often a patient will find it extremely difficult to talk about certain experiences or thoughts because he feels so much guilt about them, or better because he believes he feels guilty. When he has gained sufficient confidence to talk about these experiences or thoughts, and recognizes that they do not meet with disapproval, the "guilt feelings" vanish. In the case just cited the patient's guilt feelings disappeared within a week after I emphasized to him that I did not disapprove of him and thought he was worth trying to help.

In his personal dealings with geriatric individuals, the pastor, like the physican, must remember that the older people become, the more they need explanation, support, encouragement, and appreciation. The mechanism of denial is best met by an explanation that the pastor realizes why the patient feels it necessary to do this, and then by support in a reality-oriented fashion. Recently I had to admit a chronic paranoid schizophrenic patient who had been trying desperately to make it on the outside. For her, admission to the psychiatric hospital was the greatest possible blow to her self-esteem. Right until the moment that the ward door closed behind her, she insisted that she was here only for the purpose of visiting me. When she became convinced that she was to be really admitted, she commenced to deal with the problem in a characteristic way. When I went to see her one day, she was wearing a headscarf on her head rather like a nurse's cap. She approached me saying: "Doctor, if you are going to the nurses' meeting, I am going too, for I am a nurse." There was some truth in her statement, for she had been of immense help in nursing and taking care of some of the less fortunate patients. She insisted on accompanying me to the meeting until I explained to her that I understood why she felt she had to deny that she was a patient in the hospital. After a moment she replied: "Thanks, Doc, I know I'm not a nurse, and you know I'm not a nurse, and thanks again." She left me and I proceeded to the meeting.

It appears to be a rapidly growing practice in our churches to segregate the old from the young. Separate meetings are scheduled for the teenagers and for the older members, and this is both necessary and advantageous on occasion. However, there should be many meetings of a combined nature and of a social type for the mutual participation of young and old. As a rule, the geriatric individual has no great desire to mix constantly with the young, but he is liable to become disturbed if he gets the idea that the pastor thinks such segregation is necessary. Combined activities will give him a sense of belonging to the community as a whole and not just to his own particular age group.

The older we become the more we are likely to enjoy manual tasks. Many patients learn hobbies and crafts as part of their treatment in the hospital. They spend many hours every week in occupational therapy. Perhaps the church might be able to arrange a weekly arts and crafts class for elderly people. In such a class they will once again be productive and so will feel useful. Their self-esteem will rise and they will have the additional advantage of socializing with one another.

The geriatric patient longs for a continued sense of usefulness. He wants to be appreciated for his productivity even though this may be of a limited nature. One of the most gratifying experiences he can have is to feel that he has a sense of mastery. Perhaps he can only potter around in the garden or help to look after some chickens, but even this gives him a certain sense of mastery and usefulness which is essential if the individual is to reach an adequate level of emotional adjustment.

[1]*Horney, Karen: The Neurotic Personality of Our Time, New York, W. W. Norton & Co., 1947.*

This Month's Cover

The warmth within, the glistening snow, the work of day now done.
The suffering, the healers, gathering as one.
Some are winning, some have failed, some will try again.
The lighted windows manifest each man's concern for men.
D.E.Y.

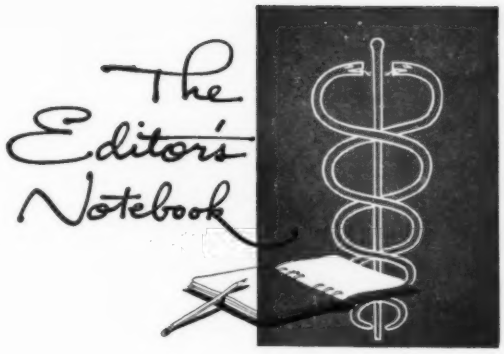
Artist George Doty has captured the symbolic warmth of the December season in his cover rendition of this building at Moose Lake State Hospital, Minnesota. The picture was sent by Irwin J. Peterson, at the request of Miriam Karlins, State Volunteer Services Coordinator for Minnesota.

OUR COMMON GOAL

I will conclude by repeating what I have previously written on the problem.[1] "Mental health in the geriatric patient depends not only on physical factors, but upon social, economic, and religious factors as well. In order to be contented in his old age, the geriatric patient requires such interests as hobbies, religion, work, and other avocations. We must remember that no person and no geriatric patient can live in a vacuum, and while it is our aim that these patients, either in the hospital or in the community, should reach an adequate level of emotional adjustment, we must give them something to which they can adjust. This is the goal of our treatment program in the hospital, and it is absolutely essential that this be maintained after the patient returns to the community. If we all could put ourselves in the shoes of the geriatric patient on the day that he is scheduled to leave the hospital, and experience the fear that he has of losing the place he formerly enjoyed in the community; the feeling that he has of having outlived his usefulness; his tremendous sense of loneliness and the fear of not being wanted by anyone in the future, then we would be able to get close to these patients; we would be able to understand and help them and, thus, have attained our common goal."

(Acknowledgement is made by the author to Mrs. R. Price, social worker, whose excellent social histories contained much of the information used in the formulation of these concepts.)

[1]*Osawatomie State Hospital Workshops, Care, 8:10, Oct. 1959, Kansas State Department of Social Welfare.*



SOME YEARS AGO, in a state hospital which had just started using the newly developed ataractic drugs on a research basis, the director of nursing education, a veteran of some 20 years in the hospital, expressed quite simply a problem which has since become recognized as one of the greatest challenges posed by the use of the drugs:

"My problems are multiplied," she said ruefully. "The patients aren't disturbed any more, so we put up drapes, bought rugs, goldfish, and potted plants. But while I used to teach my student nurses and attendants how to handle disturbed patients humanely and kindly, but firmly, I don't have to teach them this any more. So what am I to include in my nursing curriculum?"

Several years later, the World Health Organization expressed the dilemma in more detail:[1]

"In considering the impact of the pharmacotherapies on the management and treatment of mental disorder in a mental hospital, one is apt to be reminded of the violent changes brought about by the past introduction of other somatic therapies, such as deep insulin coma, electroplexy, and the lobotomies. Each of these has wielded changes, based essentially upon relatively short-term results; only in recent years could these be viewed against the perspectives of long-term follow-up studies. The changes in management, and the attendant changes in attitudes, however, have stayed and become cumulative. . . .

". . . The impact of the drug therapies on mental hospital population is essentially threefold. They have altered the immediate management and treatment of certain types of acutely disturbed psychotic patients; they have mobilized large chronic populations hitherto secluded in the continued treatment units of the average mental hospital; and, in individual cases, they have made possible measures of rehabilitation which would have been very difficult to achieve in their absence. Lastly, they have increased and made more urgent the contacts between the mental hospital and the community. In terms of all these effects the drugs are wielding profound changes in staff attitudes at all professional levels. . . . There seems little doubt, on the evidence so far available, that the drugs have confronted the hospital staff with a challenge unlike any challenge experienced during similar periods of transition in the past. . . ."

Today the old time-worn categories of "violent," "untidy," "acutely disturbed," "withdrawn"—all based on behavior—have become less meaningful. The drugs have reduced violence to an incident. As the turbulence of their symptoms recedes, patients reveal treasures in the form of human potentials. No longer masked by unhealthy behavior, healthy characteristics begin to appear. A man, hitherto isolated and mute, reveals undeveloped artistic talent; an elderly woman, formerly withdrawn, is capable of making a small, human contribution of affection to her grandchildren; a wife, formerly alienated from her family by her violent behavior, is plainly able to resume some of the duties of a wife and mother. The more "ordinary" becomes the behavior of the patients, the more individuality each one reveals.

This is the challenge which the nursing educators have met bravely and are continuing to meet. Today they teach all ward personnel that, for every unfulfilled potential in a patient now accessible, there is a need which must be met—a normal, human need, not a pathological one caused by the illness. The task of ward personnel is to observe, to report, to understand, and to meet these needs.

The nursing service is no longer protectively custodial, but subtly observant, warm, and friendly. Now that nurses and aides are living with "people" instead of struggling with "patients" during their working life, there is a lessening of their own feelings of tension and isolation. Now they can go home with some sense of accomplishment, of richness, not to be obtained by preventing a man from hitting his head against the wall. Now they can remember how Mr. Smith suddenly picked up an old guitar and revealed an unexpected talent for folk singing, or how Mrs. Jones, working on a child's dress, talked at some length about her own children, after months of silence and withdrawal.

And with their daily awareness of the patients as people has come something else—a personal recognition that there is a role for the community to play; that their friends and neighbors, as well as they themselves, are capable of giving something which these people need and will continue to need after discharge. So the ward workers have become, in a quiet, sometimes unnoticed way, enthusiastic missionaries to their fellow citizens.

Many of the drugs are untested; they have not been with us long enough for proper evaluation. They do not cure, and we are still far away from the answers to the mysteries of most mental illnesses. But, while the drugs did not *cause* the development of the therapeutic community, did not lead *directly* to better hospital-community relationships, they have certainly facilitated and contributed to these movements. Let us be grateful, not only for the assistance of the drugs, but also for the quickness, the courage, and the creativity of the nursing educators and the ward workers who saw the opportunity, and helped us to harness this new helper.

Matthew Ross, M.D.

[1] *Tech. Rep. 152: Ataractic and Hallucinogenic Drugs in Psychiatry, Rep. of a Study Group: Geneva, 1958.*

By HOWARD M. FEINSTEIN, M.D.
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The Young Psychiatrist in Military Service

PSYCHIATRY HAS GROWN MUCH from the experience of the military services during two world wars. The multiplicity of emotional illnesses resulting in noneffectiveness drew attention to the vast need for physicians trained in this area. Many psychiatrists increased their professional skill and understanding, handling millions of men who could not meet the demands of their society and function in the soldier role.

In the period between wars, however, military service seems less pressing and more burdensome, particularly to the young physician who has two more years added to an already lengthy training period. Thus he is likely to overlook the unique professional experience afforded by military psychiatric practice and postpone, if possible, his service obligations. Having recently completed a tour of duty in the Army Medical Corps, I am writing this article in an attempt to inform other residents and also to remind psychiatric educators of the abundant opportunities for the maturation of a psychiatrist in the armed forces.

The military psychiatrist is in a unique position to study and treat behavioral deviations. During civilian residency, it is common for clinical experience to be limited to the social group served by the training hospital. The resident who trains in a small, private institution may never know the indigent man who is mentally ill. The large public institution is filled with mentally ill individuals from lower classes but rarely provides the resident with an opportunity to become intimate with the language and problems of the leaders of society. The military psychiatrist, on the other hand, becomes familiar with the failures of adjustment at every level of military society—through the enlisted ranks to the general staff. He is not class-bound by his patient-bias in viewing maladjustment.

Increasing the range of human experience takes place in other ways in the military setting. The bias of regionalism is overcome. Rare is the urban-trained psychiatrist who has devoted time to understanding and communicating with someone from the backwoods who has never heard of Sigmund Freud but who is in emotional difficulty. The military psychiatrist works daily with maladjusted service men from all backgrounds and from every section of the United States, and he is presented with the perpetual challenge of talking a mutually understandable language with each of them. For the physician who wonders about the cross-cultural validity of his dynamic concepts, here is his opportunity to test them in other subcultures—not with statistical accuracy perhaps, but with resulting increased awareness of his own limitations.

Military psychiatric practice is unique not only because of the range of classes and subcultures encompassed. The military psychiatrist is an active participant in the life of the community he serves. The physician in a civilian setting (or residency), who stays closeted with his patient, is limited in his ability to assess what has taken place outside of his office. In contrast, his military colleague knows the major environmental shifts, such as overseas shipments and separation from family, because he experiences them himself—he lives within the same milieu. He knows intimately the reality factors which may precipitate the role change from soldier to patient. Furthermore, he can freely communicate with unit commanders or other key figures to take realistic measure of the patient's world. Questions of professional confidence limit this approach in a civilian setting.

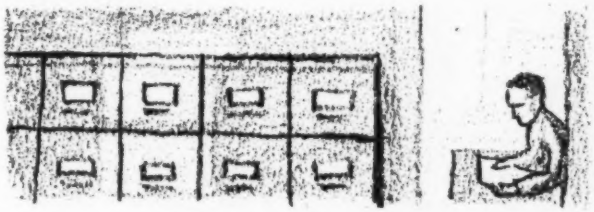
Other practices indigenous to the military medical setting provide unusual opportunities for the research-oriented physician. He has access to complete records of all medical contacts from the patient's date of entrance into the service. Frequently one encounters records covering fifteen or twenty years of service which can document the insidious development of psychiatric disease processes. In addition, follow-up of patients is easily controlled. The physician who is interested in the results of therapy in any individual, or in studying a large group participating in a research project, can have the patients brought back with a high expectation of their appearing as appointed. By not being dependent upon voluntary participation, he has an unusual opportunity for studying this population. This is especially useful in an outpatient

setting. Obviously, civilian installations cannot have as much control for investigation in this area.

In addition to providing diverse clinical experience within an environmental field known to the doctor, military service may extend professional activity into more unfamiliar areas, such as legal psychiatry, penal psychiatry, or psychiatric administration. Unless the civilian training hospital cooperates with the courts or other social institutions in the evaluation and management of legal offenders, psychiatric residents are likely to have little more than academic knowledge of this area. Penal and legal psychiatry are integral parts of military psychiatric practice. Violations of the military code often signify failing social adjustment. The psychiatrist is called upon to aid military authorities at all stages of disciplinary action. Pretrial psychiatric evaluations are made when questions of mental illness and legal culpability are raised. In performing such an evaluation, the young psychiatrist may, for the first time in his career, be called upon to force medical terminology and experience into the rubrics of "legal sanity." During a trial he may be called upon to testify either in person or through written report. Here he can gain experience in translating technical findings into language which is understandable to nonmedical members of the court. After sentencing has taken place, he is often called upon to participate in managing the prisoner within the confinement facility.

Military experience also brings the psychiatrist into contact with a very special type of public health problem. The military code sets up restrictions, some of which are unusual in the civilian setting. Many minor offenses which would go undetected outside the service are punishable under the code. This brings many minor offenders, whose actions are symptomatic of characterological difficulties, to the attention of mental health services. Since civilian training is largely hospital-oriented, the resident is likely to have experience only with extreme examples of character and behavior disorders. Upon entry into the military service, the young physician may well be astounded by the tremendous number of young men who are crippled by brittle behavior patterns. The opportunity to observe the large numbers of noneffective personnel makes him realize the futility of using face-to-face or back-to-couch therapy in coping with this health problem.

There are other subspecialties within the field of psychiatry in which trainees do not usually participate until late in residency programs—often in an additional year of training. Though the resident usually has responsibility for ward management, he is rarely charged with other problems of administration. It is not uncommon for the service psychiatrist to be called upon as an officer to assume charge of the administration of his unit. Though securing adequate supplies, maintaining record systems, or hiring secretarial personnel may seem tedious chores, they are nonetheless often necessary, and may provide invaluable experience for those who plan office practices. In fact it is good practice for any physician to be aware of the problems of operating a psychiatric facility, so that he may be more appreciative of the efforts of others in this field.



There is ample opportunity for teaching within the framework of military psychiatric practice. Teaching is necessary at professional and nonprofessional levels. The military services have developed a system which utilizes nonprofessional personnel who are service-trained to assist workers in the mental health field by performing such professional activities as taking social histories. The psychiatrist often helps train such men within his own unit or in service schools. Teaching may extend outside the psychiatric unit in the form of lectures to nonmedical personnel, covering specific problem areas such as alcoholism or suicide. The school authorities on the post may call upon the psychiatrist to participate in P.T.A. speaking programs. In the civilian community most of these services are usually provided by older, established physicians, but in the transient military community such opportunities are open to the young psychiatrist.

If the psychiatrist is to adjust himself to practice within the military framework, he must shift some of his values. Of necessity he thinks in terms of large bodies of men. The emphasis is on the goals of the group, and the welfare of the individual must oftentimes be considered of secondary importance. This shift, though justified by the needs of the service, may be difficult for a physician to make, and he may become overly involved in "bucking the system." All of his prior professional training will have implicitly and explicitly emphasized individual well-being, particularly in the mental health field where so much attention is focused upon the microcosm of intrapsychic functioning, and the individual patient is the unit of interest. Even if the view has been expanded to a group approach, this is likely to be aimed at individuals through a social experience. On the other hand, the military psychiatrist's major goal is to support the military mission, and his primary unit of interest is the large group. The individual usually comes under scrutiny only because of interference with the operation of a group. Fundamental to psychiatric evaluation under these circumstances is an estimate of the individual's ability or lack of ability to contribute to group effort. Individual therapy is justified if it restores, maintains, or increases the individual's capacity to function effectively in his organization. At times, measures are taken which

are "therapeutic" for the group but which may be less advantageous to the individual. The psychiatrist may be called upon to implement such actions. Even if he does not make this change in values wholeheartedly, working within the framework of a different system will contribute to his professional understanding. It throws into relief theoretical propositions implicit in one's previous thinking.

In addition to the professional experiences described above, military service offers some personal advantages which should be mentioned. The psychiatrist receives a substantial salary. For the first time since embarking upon a medical career he has an opportunity to move out of a slum apartment and off a spaghetti diet. In addition, the cost of maintaining a comfortable standard of living is relatively low at military installations, which are often pleasant, self-contained communities. This, coupled with the substantial salary, enables the young physician to save funds which will help finance further training or practice.

This discussion has emphasized the positive side of military psychiatric practice. To some, the description may seem excessively biased in this direction. Certainly there are uncomfortable assignments and uninformed commanders, and separation from family and friends does take place. Colleagues and popular myth constantly describe the unpleasant side of military life. But to emphasize this and ignore the rich personal and professional experience possible within the framework of obligatory service is a foolish error. •

ICE CREAM CUTS DESSERT COSTS

CENTRAL ISLIP STATE HOSPITAL has solved several food service problems common in mental hospitals by installing a simple but systematic way of producing and serving its own ice cream dessert. First, it solved a budget problem. Food and package costs are under 2½ cents per portion, making ice cream the cheapest possible dessert. Secondly, it minimized the difficulty of serving dessert to a patient population with a high proportion of elderly people whose food must be easy to digest, appealing, low in calories, and nutritious. A single portion of ice cream gives patients a significant amount of needed calcium but it contains less than 200 calories, a favorable figure compared with many other desserts. And it is so popular that seconds and thirds are often wanted at meals as well as when it is served at patient parties. Third, the hospital simplified the task of serving dessert to 10,000 patients who must get their food through 53 cafeteria-style dining rooms. Once the dessert is made, handling is kept to a minimum by the new method.

The system works as follows: The ice cream making operation has been set up in an unused special diet section of one of the seven central kitchens where food is prepared. A ten-gallon freezer with compressor; a manually operated paper-cup filler with a little conveyor; a twelve-foot steel table; and sets of racks and dollies for holding paper cups have been installed. A nearby small walk-in refrigerator formerly used to hold frozen foods, has been converted into a hardening room by adding an extra compressor to bring the temperature down to between -10 degrees and -15 degrees Fahrenheit.

Four days a week, six hours a day, two men in the food service department make ice cream. Using dairy-prepared ice cream mix in three flavors (chocolate, vanilla, and strawberry) or the hospital's own ice cream flavors added to a basic mix, they pour five-gallon batches into the ten-gallon freezer. In less than half an hour the ice cream is whipped and frozen, ready to be drawn off and poured into the hopper of the filler.

After the cafeteria counter girls, who are available for other work between serving times, have set up pleated paper containers in racks, one of the men feeds the cups through the filler while the other operates the three nozzles of the filler. In three minutes a complete batch is poured into paper cups, which are capped with lids by the counter girls. The racks of cups are re-stacked by the girls and wheeled on dollies into the hardening room for service the next day.

The following morning the hardened cups of ice cream are simply dumped out of the racks into five-cubic-foot polyfoam boxes that hold 400 to 500 portions. Two hours before serving time, the boxes (in hospital-made metal covers to cut down abrasion) go out to the dining rooms on trucks. These lightweight boxes are simply put on the counters for service, and a counter attendant removes and serves the cups with tongs.

With this system, there is virtually no handling. Preportioning the ice cream into pleated paper cups when it is made reduces service costs and variations in the size of portions. It eliminates serving time and dishwashing that would be necessary if the ice cream were served from bulk containers.

With this equipment, a considerable variety of frozen desserts can be made, and, furthermore, about 60,000 portions can be produced and served three times a week.

The cost for the dairy mix is about 34¢ a quart and the paper cups with matching lids are very inexpensive. Equipment for the entire installation, including the accessory racks and dollies is under $5,000. Since it is uncomplicated and easy to maintain, it can be amortized over at least a ten-year period, and it certainly more than pays for itself.

GEORGE HOWARTH
Food Service Director

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1. Cameron, E.: The Use of Tofranil in the Aged, Canad. Psychiat. A. J. Special Supplement, **4**:S160, 1959. 2. Christe, P.: Indications for Tofranil in Geriatrics, Schweiz. med. Wchnschr. **90**:586, 1960. 3. Schmied, J., and Ziegler, A.: Tofranil in Geriatrics, Praxis **49**:472, 1960.

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Patient-Oriented Administration In a Day Hospital

By RAQUEL E. COHEN, M.D.
Staff Visit
Massachusetts Mental Health Center
Boston

THIS IS A PRELIMINARY ATTEMPT to present a novel plan of psychiatric administration, based on the premise that the establishment and day-to-day functioning of a "therapeutic environment" should be at the level of individual interactions between the patients and the members of a team carrying all the administrative responsibility. This is in contrast to the classical administrative method wherein the staff members' reports to the chief of service constitute his only source of intimate knowledge about the patient. It is also in contrast to services where teaching is one of the main functions and each medical resident is responsible for some administration.

The administrative structure described herein was established in the day-hospital unit of the Massachusetts Mental Health Center at a time when the unit was semi-autonomous and only partially integrated with the general teaching and training plan for the center. The concentration of all administration in the chief of service was carried out by a division of responsibilities. Patients were assigned to second-year residents, who were responsible for psychotherapy. The chief of service handled all matters pertaining to daily living problems in the hospital.

There are notable differences between the orthodox twenty-four-hour care unit and the day-hospital service. The two areas of greatest difference are in the role of the psychiatric nurse and in the characteristics of the patients as a functioning group.

ROLE OF THE NURSE

The nurse's role is much more clearly defined in the day hospital than it is in the usual full-hospitalization setting. The schedule allows for one shift of nurses to be in constant relationship with the patients, thus providing a continuous team approach which intensifies these therapeutic relationships. Because housekeeping routines are reduced to a minimum, if not completely eliminated, personal contacts emerge as the primary nursing responsibility, and the development and formulation of psychiatric techniques in nursing are afforded a wider scope. This is illustrated by the case of Miss B., an angry, frightened patient who handled outbreaks of her emotions by shouting, crying, and banging her head against the wall, or by paranoid defenses which isolated her from staff members from whom she had previously been able to get help. The successful re-establishment of this patient's relationships with the staff was effected by one staff nurse whose therapeutic handling of a dramatic acting-out episode made her acceptable to the patient.

On a different level, the high degree of activity and interest in the recreational program of the day hospital is attributed primarily to the fact that the nurses direct it. Here, relationships that are on a continuous basis are used to stimulate the patient to participate in activities which he is often reluctant to initiate, but which he is encouraged to undertake because the leader is known to him, even though the activity may be unfamiliar.

As a group, patients in the day hospital present a different image than the classic one of hospitalized mental patients. The members of the staff, in trying to understand the characteristics of this disparity, discovered that the dependent-independent ratio in their daily relationships with the patients was not only different but extremely important. On a twenty-four-hour service, because of the implications of personal nursing care in housing, sleeping, and hygienic needs, the patient tends to accept his relations with the staff in a more dependent manner. This is in contrast to the day-hospital program where most needs are psychological, and the patient is minimally dependent upon physical help; thus he exercises a more independent attitude toward personnel, which in turn affects his emotional relationships with them.

Some elements of the difference in the patient picture have their origin in the fact that the day-patient comes and leaves regularly of his own will. The daily trip to the unit is an activity which lends itself to a variety of acting-out conflicts in which the patient can "voice" many feelings. One of the emotional messages seems to be, "I come to get help in getting better, now show me how that can happen here." The day-to-day repetition of this expression serves to make the staff very conscious of its role in "the contract."

An element of immediacy, stemming from his daily interaction in the community, is another important aspect

of the emotional life of the day patient. The following episode illustrates what is meant by immediacy:

> Mr. A, a retired 69-year-old trailer-truck driver suffering from a depressive mood, mild paranoid and hypochondriacal symptoms, called one morning to say that he was going to "sign out" of the day hospital. The head nurse suggested that he might come in and discuss this with the medical administrator. Half an hour later he came in and told the nurse that he couldn't wait too long, since his son, who usually drove him, was waiting to take him home. The doctor, who had a good relationship with the patient, asked the son to join them. In the conference that followed, several factors which had precipitated the patient's angry gesture became clear. Dominant was the fact that the son was unable to drive the father to the hospital for several days. Because the patient had to take the subway, he felt his somatic symptoms had been aggravated. The son, in turn, was able to verbalize his annoyance at having to perform this daily obligation. To ameliorate the needs and difficulties of both men, the doctor reduced the patient's attendance at the day hospital to three days a week, and arranged to have his days terminated at an earlier hour than usual, to avoid rush-hour traffic. The immediate handling of this problem bypassed the realistic friction fomenting the situation in this family and averted an impasse with the patient.

PRESCRIPTION-TYPE CARE

The staff conceives of a therapeutic climate as one in which its members use the opportunities arising in interrelations with the patient to orient themselves toward what is beneficial for him, rather than toward the establishment of a routine which makes it easier to run the service.

The fulfillment of "prescription-type" care within the structure of a large group of patients is of primary importance. This implies finding the necessary approaches to each patient and applying them consistently. One patient, for instance, tended to ask staff members for help in making decisions by presenting the material in a global, diffuse, ambiguous manner. The staff decided that he should be helped with the "here and now" problems of interacting in the unit. They remained steadfast in this mode of assistance, helping the patient to communicate what was really bothering him, while at the same time aiding him in feeling the real meaning of communication with people as opposed to his own defensiveness, which set him apart from them. This technique has positive application in the relationships which keep developing between the patient and the administrative staff.

Another example can be found in the case of a female patient whose persistent and obstinate demands for different drugs made her treatment a continuous shifting of medication. The staff achieved satisfaction of both her demands and her need for consistent drug therapy by establishing a program of writing weekly orders and seeing her at the end of the week to determine if these should be renewed. Under this method, she did not ask for the orders to be changed and seemed satisfied to continue on the same regimen.

Active leadership in the *clinical* field of psychiatry stimulates staff awareness of patients' needs by pointing out examples that clarify what the patient is experiencing or what specific incidents mean. Daily rounds and informal occasions afford natural opportunities for such stimulation. The *administrative* staff concentrates the bulk of its daily activities on finding practical ways in which the patient can be helped. The continuous relationship with the individual patient enables the staff to have a better and deeper understanding of the daily problems. Two important factors facilitate this situation. One is the fact that the administrative staff, medical and nursing, is "housed" in the setting where patients congregate; the other is the establishment of a continuous and flexible line of communication. These enable the staff to "synthesize" into action the therapeutic elements needed by a specific patient at a specific time.

CONTINUOUS AWARENESS

The active endeavor of this method is to strive to learn everything about the individual, his social attitude and methods of relating, his home situation, and current conflicts. Although many of these factors are already established, there are some that are in continuous change, and this alerts the staff to a "continuous awareness" in order to keep pace with the patient.

The amount of information about the patient varies with the source of admission. When a patient is transferred from the inpatient service, a preliminary staff presentation precedes his formal admission to the day hospital. Valuable material thus becomes known, and from this the senior staff develops a treatment plan which serves as a continual reference in further evaluation and flexible modification. With patients coming from the community, however, the information is not so complete, and much important material must be obtained by the medical administrator in the preliminary admission interview. This information and that gathered by the social worker are shared at informal meetings prior to the staff presentation.

Daily knowledge about the patient is gained through several methods of interaction. The nursing staff has the most continuous contact with the patient in activities shared together, such as group meetings and/or individual talks in the nursing office (a great socializing center). Also, there is usually a group of patients who have to be called on the phone to find out why they did not come to the hospital. These telephone conversations are very important in the daily routine, and offer many opportunities for therapeutic maneuvers.

ROLE OF THE MEDICAL ADMINISTRATOR

The medical administrator has created an opportunity to gain further knowledge about the patients by establishing a policy which encourages them to come into the office any time the door is open. Unscheduled time is set aside for this daily, and the patients use it frequently, according to their needs. At other times the doctor min-

gles with the patients in the lounge and informally finds out how they are feeling or learns the outcome of some important decision.

Part of this technique is the maintenance of a relationship with every patient at the level where it meets the patient's current needs, with the doctor taking an active part in promoting a "how are things" type of talk. This can be done very casually and informally anywhere in the hospital, or more formally in the office, but it is always on a continuous basis to facilitate flexible planning around the patient's changing needs. These needs fluctuate with acute episodes of an emotional nature, new medications, somatic disturbances, or new job experiences.

DAY-BY-DAY CONTROL

A further approach to helping the patients strengthen their own control and make better use of it has been accomplished through a technique borrowed from Alcoholics Anonymous. It consists of limiting the need to maintain control to a short time only, usually until the next day when the patient can sit down again with the doctor to discuss the specific problem. The possibility of daily follow-up of acute processes, be they physical or psychological, is of primary effectiveness in developing the patient's confidence that he is receiving good care.

These daily sessions offer the staff more detailed understanding of the patients' current conflicts. Not too much time is needed for each patient, 10 to 15 minutes usually being sufficient. Several factors may enter into this type of intervention. The doctor greets the patients and states the issue to be discussed, as for example, "The nurses have informed me that you have a headache—tell me about it." Or, on an occasion when a patient asks to come into the office, the doctor may ask, "What is the problem you need help with?" In this manner the specific issue to be discussed is approached and the patient is helped to settle it. If the area properly belongs to the psychotherapeutic hour, the administrator will help the patient by conveying to him that "this is something for you and your therapist to talk about as it would not be helpful for you to discuss it with me."

At times a patient will be in an acute state of panic, agitation, or anxiety; here the previously established relationship pays off, because the administrator can supply a short, supportive, "marginal" intervention to tide the patient over until he sees his regular therapist. The administrator is, of course, aware that the utmost care should be exercised not to intrude into a therapeutic relationship, but his immediate availability is a good adjunct to the therapy of psychotics.

It is important to provide the patient with a comfortable and well-structured area of relationship with the staff personnel, so that there may be a clear differentiation between the type of material which belongs to administration and that which should be reserved for discussion with a therapist. This is difficult and there are many overlaps; but the administrator who is familiar with psychotherapy will be able to gauge when he is in a territory that does not properly belong in the administrative situation.

In making plans for the individual patient, the staff considers and discusses his point of view and includes it as much as possible in the decision making; the main consideration at all times is what is best suited for the patient at a specific time in a specific set of circumstances. This approach seems especially well fitted for a day program because of the multitude of variables that appear in the daily life of each different patient. Also, because the day program is not encumbered by traditional methods of administration, the individual and flexible approach can be established without having to run counter to previous customs.

This individual patient-oriented plan has eliminated many of the problems that arise from patients' reactions to rigid schedules in the more structured type of administration. This is clearly seen in the flexible discharge process established in the day hospital. The method best suited seems to be for the patient's attendance to be reduced to three times a week, until it is ascertained through talks with the administrative staff that he is comfortable with this schedule. Thereafter he comes in twice a week, and then once a week until final discharge.

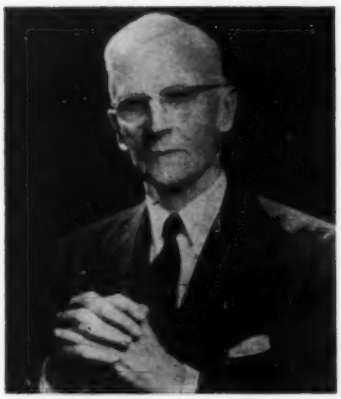
Flexibility of operation must not sacrifice the "steady world" which the psychotic patient needs in order to get his bearings. Thus, a clearly oriented treatment philosophy is of great importance. This can be obtained by developing a homogeneous staff approach in dealing with problems. To this end the leadership of the administrative team endeavors to keep clarifying and interpreting along practical lines the theoretical therapeutic approaches to the main goals. However, it must be stressed that a continuous awareness of the daily events can be used in a dynamic way only if communications among the team are kept open, and if the physician-administrator realizes that it is just as important to continuously impart information to the staff as to receive it.

FLEXIBILITY IS THE KEY

The degree of effective application of a plan such as that described here is influenced by the quality of the relationship between staff and patients, and is in a continuous state of fluctuation. To keep applying dynamic principles to clinical administration, the staff must be flexible enough to adapt itself and certain of the environmental factors to the actual needs of the individual patients. The complex population of the day hospital and its many relationships to the community made the application of this administrative formula a stimulating and creative endeavor. •

Ed. Note: At the time this article was written, the author was chief of the day-hospital service at the Massachusetts Mental Health Center. The plan she describes grew out of her interest in finding practical applications for psychoanalytic principles in hospital administration. With the advent of a new chief of service to the day hospital on July 1, Dr. Cohen transferred to the regular hospital program where she is currently adapting her administrative formula to the care of inpatients as well as outpatients, and incorporating it into the general training program of the center.

Number Four in a Series by Past Presidents of A.P.A.



THE PEOPLE OF A GOOD MENTAL HOSPITAL

By EARL D. BOND, M.D. (1929-30)
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HOSPITAL BUILDINGS ARE IMPORTANT, but it is the people in them who make a good or a poor institution. Many fundamental rules concerning the organization and requirements of these people were laid down in 1850 by the founders of the American Psychiatric Association. I have published these century-old principles before, and I repeat them below in italics, adding to them the new ideas of 1960.

1. *The physician-in-chief should be the superintendent officer and free of politics.* Responsibility cannot be divided.
2. *There must be no overcrowding which becomes an apology for what otherwise would not be tolerated.*
3. Nurses, occupational and physical therapists, attendants must be qualified by *tact, patience, a real interest in their work, a sympathy that cannot be questioned, a sound moral character.*

In 1960 a way to strengthen the weak link in personnel —the attendants—has come to light. It is understatement to say that attendants are responsible for the treatment of patients in our large psychiatric hospitals. They are with patients 24 hours a day. Without attendants, hospitals would close. Nurses supervise and are legally and professionally responsible for drug therapy; attendants work with patients.

Yet an outdated situation is kept going in many of our psychiatric hospitals. It is the practice of "living-in," adopted when such hospitals were supposed to be walled off from the community, when every employee was supposed to be on call 24 hours a day, and when the superintendent and the employees were supposed to eat what the patients ate.

Now or in the near future every employee should live out, except those in training. Take the men attendants first. After a period of training during which a man shows good character and during which he receives little pay, he should be promoted, if satisfactory, to full employee status and good pay. What is good pay? About what an automobile worker in a service station would get. A man skilled in caring for sick people should get as much money as a man caring for sick engines. The attendant should be free to marry, to set up his own family, to live like anyone else in town, city, or suburb, to be a good and respected citizen—a man to explain the hospital to his neighbors. All these considerations, with minor differences, apply equally to women attendants.

There is a tendency at present to raise attendants' wages by small increases. This is in one sense a step in the right direction, but in another sense it holds back real progress. Recently I talked with two attendants who have been four years at work in the same hospital. Both enjoy their work and want to keep at it until they can retire. One of them, whom the superintendent of nurses calls invaluable, can do this because he is unmarried and lives with his mother, who has a small income of her own. The other man, with a wife and two small children, gets along by taking on a second job. The effort is too much for him and he will have to give up the hospital work to take a job at a nearby steel plant.

NEW STANDARDS OF LIVING

In fixing salaries for the year, all old standards should be thrown away, and a study should be made of the salaries of the machinists in automobile salesrooms and repair shops. Then attendants should be hired for a 6- or 12-month trial period, with simple basic training at present wages. If satisfactory, these people should then be made psychiatric aides at salaries equal to the machinists. Thus they would have the status they deserve and could afford to live in the community and be real links between the town and the hospital.

Staff physicians should also live their private lives in private homes in the community, and be given salaries commensurate with what their colleagues in private practice are making, with adjustments for regular hours and any pension system. The confusing, confining, variable item of maintenance would then disappear. Above all, the superintendent should have an adequate salary and live in the community as the top ambassador for the hospital.

Nurses could well "live-in," as could employees in training. Perhaps 10 per cent of employees of all grades may

wish to "live-in" and may be allowed this as a privilege if they have good reasons and sound characters.

What are the main consequences of living off the grounds? Larger salaries, comparable with salaries and wages elsewhere—but less expense for maintenance, often more space for patients. Better personnel—no place for the drifter, the man who has to live in an institution, the rounder, the trouble-maker. A separate night force headed by a fire marshal for emergencies. Physicians' and employees' children with natural playmates in their neighborhoods. In the hospital, more efficiency, more patients discharged. And finally a merging of hospital and community interests and understanding.

So "off the grounds" for 90 per cent of regular personnel. The only argument against an off-the-grounds policy is short-sighted economy.

In addition, then, to the farsighted rules laid down in 1850 concerning the organization and requirements of hospital people, we have the following principles to govern our personnel policies in the 1960's.

1. All employees not in training, from the superintendent down, should be expected to live outside the hospital grounds and should be paid a cash salary without any maintenance.
2. The hospital should have laboratory provisions for clinical purposes.
3. One member of the staff should be free to conduct research and to call in outside expert help for special projects.

When all of the above rules, the 1850 ones as well as the 1960 ones, are observed, the most important people in our hospitals, the patients, will be well served. And the hospital, which "deals with the fundamentals of human behavior, will share its knowledge with its community as if it were a college. It can become a forum where patients, physicians, clergymen, and businessmen can argue and learn about the main concerns of life." Further, it will save money over "poor" hospitals because it will restore more men and women to the working population.

The rules I have repeated here are applicable to any good state hospital or, for that matter, to any large psychiatric hospital. They are simple enough, understandable enough, but they are deliberately neglected. By whom? By the public first, and by the governors and legislatures second. In today's paper (October 11, 1960), a member of the Pennsylvania Legislature calls attention to the fact that the number of attendants at the Philadelphia State Hospital has dropped from 665 to 600. He does not mention that the legislature has the cure for this state of things. Incidentally, he does call attention to the overcrowding, which the founders of the A.P.A. warned against in their fundamental rules of 1850.

The 1960's will continue or add arrangements for patients to live in and work outside the hospital, or to use the hospital in the daytime and sleep at home. New physical, chemical, and psychological treatments will be introduced. It is my fervent hope that in the decade to come each of my fellow-members of the American Psychiatric Association will make it his personal responsibility to give some of his valuable time to the state hospital nearest him. •

CONTEMPORARY COMM

Ed. Note: One of the most stimulating challenges of the A.P.A. medical directorship is the processing of the constant incoming mass of data. To share with readers of MENTAL HOSPITALS *some of the intriguing and provocative notions received in personal letters and in published and unpublished papers, speeches, and the like, is the purpose of "Contemporary Comment," a new feature which will appear intermittently in this journal.*

Mental Illness, Reversible and Irreversible

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. . . I become increasingly concerned about what I choose to term the "dead zone" in the mental illness program—the vast area of untapped resources where, as in the eye of the hurricane, the sound does not penetrate and the spark of action remains unstruck. In my opinion it is only by restoring life to this "dead zone" that we may reverse the previously irreversible, both the course of a patient's mental illness itself and the limitations of society's attitudes toward it. . . . There is no question that more and better trained personnel, more money, and better equipment for the long term treatment facility represent part of the issue; this remains one line of attack on mental illness. . . .

The cycle of irreversibility is well known to many. It begins with the hiatus between the onset of disabling mental illness and appropriate treatment. This hiatus is too often filled with repeated failure experiences for the patient, panic leading to the conviction that he cannot be helped, increasing disruption of those environmental relationships which mean security and self-esteem to him, and often the total loss of a life role to which he may return when he has improved.

. . . Help is frequently unavailable at the community level without disruption of his entire way of life. He is in the "dead zone," where the resources are all around him, tantalizingly, and where professional people are eager to help; yet help is piecemeal without continuity, or unavailing, costly, and wasteful.

Reversibility, on the other hand, requires a radical change in those past and present trends which define the hospital as the major zone of defense; even the intensive-treatment facility should be relegated to a position of last resort, prior to semipermanent institutionalization. Reversibility is movement away from the hospital, treatment of personality disorders in the midst of the dynamic forces which produce them at a community level. In

COMMENT

this context, the family doctor becomes the chairman of the board . . . around him, other treatment resources are organized, with primary emphasis on outpatient clinics, psychiatric facilities in general hospitals, and "open" hospitals for psychiatric patients who benefit from partial but not total participation in the community.

. . . I have expressed my own firm conviction that it is possible to manage our mental health problem with the serenity and consistency we achieve in many other areas, to accept it as an integrated part of our national life rather than relegating it to the isolated status of something we sporadically and helplessly worry about. The direction in which the solutions lie is clear, and the diagrams are very nearly complete. At one time, the mental hospital was a humane and enlightened concept in the treatment of mental illness, infinitely preferable to a prejudiced and destructive outside environment. Time and pioneering effort have altered this situation, until the dynamic community has become a vast untapped therapeutic resource. The moment has come to reverse the trend of movement toward the hospital and encourage movement away from the hospital, to reverse what was previously irreversible. (J.A.M.A. 171:377-381 [Sept. 26] 1959.)

Personal Hygiene

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I recently heard of a mental hospital in which no toilet paper was available in the toilet cubicles. Patients had to go to the nurse and request it. This is a shocking disregard for patient dignity. And in this connection, each toilet should be provided with a swinging door to give the patient privacy. Likewise, in this same hospital, no soap or paper towels were available in the washroom. If we believe in the personal dignity of our patients, let us practice it.

We men feel better for a daily shave. Our men patients would also enjoy this. But how many of them get it, and how are they shaved? Thirty years ago in the Whitby Hospital, Ontario, we placed electric shavers on all men's wards. Every man was shaved every day, by himself, by a staff member, or by a specially trained fellow patient. We never had an unfortunate incident, and we cut our shaving costs in half. If you introduce this plan, you will be impressed by the remarkably improved appearance and morale of your men patients. But be sure to get enough of the best and strongest shavers available, and be sure to keep them well-serviced.

The High Cost of Psychiatric Segregation

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When Innocent III founded the city hospitals early in the 13th century, it was specifically stated that provision was to be made for the care of the mentally ill within them. In the intervening years and centuries, this admonition was forgotten and the mentally ill were isolated, neglected, and treated contumeliously. As time went on, medicine, which advanced with the seven league boots of a giant, pursued its scientific bent and identified itself almost completely with the basic physical sciences and the laboratory, and no place was left for the study of either emotions or the mind, let alone the antics of the poor and forlorn who were bereft of their reason. . . .

. . . . Years have telescoped into decades, and decades into centuries since this cleavage between physical and emotional ills was made and, concomitant with it, the whole facade of illness has changed. The battle against physical disease has been waged vigorously and, as a result, vast territories have been and are being conquered. The battle against mental disease has been largely neglected and succeeding generations have been decimated by its ravages. Despite apparent advances, this same situation continues today and it is evident that the only way to begin to attack the problem is to apply current psychiatric knowledge on a much wider basis than ever before. It is only through the interest and cooperation of physicians and general hospitals that real progress can be made in preventing and effectually treating the myriad of patients affected by mental disease. Only in this manner can an effective approach be made to the many physical disabilities that are rooted in emotions.

Psychiatry cannot handle the problems which face it alone and it must always be remembered that many of its new patients are the old patients of other specialties. There are numerous proofs of the need for reintegration and a closer alliance of psychiatry with general medicine, none more dramatic than those individuals in whom the actual relief of a physical disorder has been promptly followed by the emergence of a full-blown psychosis. To use a word presently popular in the public press, the cost of the segregation of psychiatry from general hospitals has been high, emotionally, financially, in bed space, and in time. . . . (Psychiatry in General Hospitals, Hosp. Prog., 41:9:58-61, Sept. 1960.)

Constructive Utilization of Acting-Out Tendencies

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THE AWAKENING OF THE PUBLIC through our mental health programs has led to a readier acceptance of psychiatric help. More and more patients of all ages, psychotic or not, with acting-out, aggressive, manipulating, or self-destructive impulses are being placed in state hospitals by a distressed public. Some of these newly admitted patients join the ranks of the chronic ones who have been populating the back halls for years with their apparently unchangeable behavior patterns. Others, particularly the younger ones, tantalize the hospital by using it as the stage for their unpredictable, antisocial acting-out. The hospital community is faced with the task of maintaining its emotional balance, which these patients seek to undermine. The patients, even though they resist help, must be treated. In frantic self-defense, the chronically understaffed state hospital concentrates the efforts and the time of a disproportionately large number of its medical staff and personnel on this minority of patients.

In the face of an anticipated influx of acting-out patients and little prospect of an appreciable increase in personnel, this problem has to be solved with the means which are available. For the hospital to fulfill its obligations, the patients must be treated successfully. At the same time, the hospital and its community must remain functioning without the necessity of an uneven distribution of its members. We wish to describe an experiment in providing this kind of treatment.

THE SETTING

One of the wards (E-3) for disturbed women at the St. Louis State Hospital was an ideal testing ground for the experiment. Its main function was to absorb the patients who had created intolerable disturbances elsewhere in the hospital by their assaultive and manipulative behavior. These patients had been treated with maximum dosages of ataractics and still required a considerable amount of hydrotherapy in the form of cold wet-sheet packs to handle their anxiety.

For the fifteen months (July 1957 to October 1958) preceding the experiment, the hall census consisted of 56 patients ranging in age from 17 to 76, with a variety of psychiatric diagnoses, but having in common certain behavior disturbances. They were aggressive, acting-out, demanding, manipulating, destructive, self-mutilating, or impulsive. Two patients had a history of murder, some were chronic run-aways.

E-3 was functioning with a minimum of hospital staff, consisting of the ward doctor (with not more than one or two hours a day at his disposal for this particular hall), the resident physician on call for emergencies, three to four attendants for each eight-hour-shift, one occupational therapy worker for two hours five days a week, and a music therapist for group singing two hours a week. Supervisors of the various professions, if they visited the ward, avoided direct contact with the patients.

A small number of the more reliable patients had the only type of privilege granted on this ward—participation in some of the off-the-ward evening entertainments, provided an E-3 attendant was available to chaperon them. Strict rules were maintained concerning smoking, receiving gifts, visitors, or home visits. The treatment, as indicated, consisted mainly of hydrotherapy and drug therapy. The rigid ward structure was strictly enforced by the attendants, who were insecure and needed constant reassurance, as they feared the retaliation and ganging up of the patients. For these reasons, they discouraged unsupervised activities and socialization.

The patients were careless about themselves, bored, and unable to control their anxiety for any length of time. They showed pseudo-improvement, followed by a resurgence of symptoms, whenever a new doctor was assigned to the ward, or came to fill in for vacations. Since the ward was a closed-off unit, the monthly total number of packs given measured the flow of hall anxiety like a barometer, dropping from 75 to 50 with the advent of a new doctor, but increasing to almost 150 and, after a slight decline, to over 200. This figure decreased to less than 65 when the regular doctor went on vacation, but soared to 215 within a month's time. The average for the 15-month observation period was 123 wet packs per month.

The immediate objective of the ward, which was to absorb these patients from the rest of the hospital, was accomplished. Moreover, during the observation period, only six patients were able to leave the ward, and these were sent directly home.

In the experimental period from October 1958 to March 1960, the goal was not only to *separate* but also to *treat* these patients with a minimum of personnel. The personnel remained the same, except for a change of the ward doctor. Later on, two attendants retired and were not replaced. Also, after six months, occupational therapy on the ward was discontinued.

THE EXPERIMENT BEGINS

Although the strict ward rules were left intact, there was a gradual change-over to the present ward structure. The patients were activated by using their own capacity for useful and purposeful socialization. They were made more interdependent, mutually responsible, and self-reliant through group activities. Group participation was available throughout the day. Not only was it an escape from boredom, but it revived hopes of returning home through self-improvement. The following groups came into being:

1. Patient groups with no authority figure present

Working Groups: The patients assume full responsibility for the planning and performing of all the ward chores. Depending upon their adaptability, the patients fall into two working groups, one for rotating and one for nonrotating chores. A work schedule is made up by the patients themselves and posted on the bulletin board.

Entertainment Groups: Parties are initiated, planned, and carried out by the patients on various occasions. The rule is to form a committee of ten, with each member forming a subcommittee with five other patients. Community singing and dancing are conducted daily after supper by one patient who is a pianist. Most of the patients participate. In addition, those patients who had been permitted to go to some of the evening entertainments off the ward voted in new members at the risk of losing their own entertainment privileges for any patient's disorderly conduct off the ward.

Learning Groups: There have been two kinds of learning groups: one conducted by the patients with the aid of self-learning manuals, and the other taught from regular school books by educated patients. In either case the time-period has been from one-half to one hour daily. The self-taught subjects have included typewriting (11 patients), arithmetic (15 patients), and spelling (8 patients). In the more formal sessions, English has been taught to 9 patients, and shorthand to 11.

2. Activity groups with authority figures present

The music therapist has continued to conduct community singing once a week for two hours. There is also a ward attendant who supervises the sewing groups and helps in the cutting of patterns, since the patients are not entrusted with scissors except under supervision.

3. Group meetings with the doctor

These meetings have the purpose of developing group belonging. They are unscheduled, brief, requested by the doctor or by the patients who belong to any of the foregoing groups. Those patients who participate in more than one group meet with the doctor more frequently; the patients who have dropped out of groups cannot participate in the doctor-patient group meetings. As a matter of fact, very few patients had dropped out, and when these found themselves excluded from the group meeting with the doctor, they returned to their activity groups voluntarily.

4. Individual interviews with the doctor

These are initiated at the request of the patient, at the suggestion of an attendant, or by the doctor himself, who asks patients he thinks will benefit to come in for an interview.

5. Weekly meetings of the doctor with attendants

The early discussions in these meetings tended to allay the attendants' anxiety in the face of the changes which gave patients a choice of participation in activities, mutual responsibilities, and self-determination. Later discussions focused on the therapeutic significance of the activities. Daily discussions between the doctor and the charge-attendant, or any other attendant who so requests, supplement the weekly meetings. This is to maintain the attitude that the patients can help each other, can work without supervision, and need to keep practicing these healthier activities.

A REWARDING EXPERIENCE

All of this did not, of course, happen on the day the observation period ended. It was a gradual process and it was 10 months before the present program evolved. The experience was rewarding. More than half of the original 56 patients progressed and could be moved on to better wards; three of the patients returned home directly. The resulting vacancies were filled with new patients from the same category. Only seven patients failed to participate in the activities. All of the others participated and showed at least some improvement. For instance, all six patients who were self-multilating discontinued such practices. Three of them are on open wards now. Another of them will be discharged directly from E-3. One patient had torn her clothes for years, was incontinent, and had to be constantly restrained to protect her from bumping her head against metal objects. She now socializes, participates in arithmetic classes, and goes home regularly over week ends. Evidences of hallucinations and delusions decreased in many of the patients, and the dosage of tranquilizers was appreciably reduced in almost all cases.

The attendants feel more secure, in spite of their reduction in number. Their time is no longer taken up by working with combative patients, and they now speak of "our patients," rather than "this type of patient." The few cold wet-sheet treatments (27, as compared to the previous average of 123 per month) are now most often requested by the patients themselves, who walk to the present two-bed treatment room. The large room formerly used for these treatments has now become a dormitory, leaving more space available for socializing.

The ward atmosphere has lost all semblance of a disturbed ward. The new patients, who could not get

along on other wards, have adjusted themselves rapidly to the present ward program. They were sponsored by the other patients and coaxed into enrolling themselves in one or more classes. Even the teenagers, quite unlike their former selves, study and participate on their own. All activities have been voluntary.

DISCUSSION

Aggressive or acting-out behavior is a futile destructive attempt to counteract anxiety. It regenerates and increases anxiety whenever a patient is given the opportunity to go through with it. Each of the patients on this ward had the potential and also the urge to use her abilities for constructive activities, but this urge had been suppressed for the individual reasons that originally put these women at odds with society. The positive quality in the ensuing conflict between wanting to contribute and wanting to destroy often remains unnoticed in the sociopath, who attempts to hide the conflict by a futile attempt at overcompensating in self-glorification: "I am so useful to society that I need to be noticed for my special contribution."

The different types of patient groups originated in the patients themselves. The doctor merely detected the clues—the demands, the negativism, the manipulations—and injected them back into the patients with encouragement. As these patients become aware that the doctor knows of their anxiety, they begin to feel understood, and as they learn to decrease their anxiety by constructive activities, they begin to feel helped. In response to their relief, they begin to accept hospital authority figures, and society becomes less threatening. For example, the beginning of the learning groups originated in one patient, who tried to manipulate the doctor. This patient was 19 years old and had quite a history of antisocial acting-out. She asked for permission to participate in the off-the-ward school program, in order to finish high school. This would have given her an excellent opportunity to escape from the hospital, as she had done on previous occasions. She said she needed to learn arithmetic, indicating that this had a particular meaning to her. She was given a self-learning manual for arithmetic on the condition that she share it with others. She thus found herself trapped and forced to offer her services to the other patients, whom she disliked because she thought they hated her. To her surprise, 15 patients accepted her invitation and wanted to participate.

The use of the self-learning manual has several advantages; it decreases the tendency of self-glorification, since each patient may be the teacher. It also enforces discipline during classes, as the pupil-patient begins to identify with the teacher-patient, anticipating retaliation should she herself become the next teacher. This is a bridge to identification with an authority figure. The teacher-patient herself enjoys and wants to maintain her role as an authority figure. She realizes she cannot do this by scholastic skills alone, and she therefore picks up social skills from the only representatives of society she now has contact with, the attendants and the doctor. Thus she begins to identify with authority.

Similar clues given by other patients resulted in the formation of the work-rotation groups, mutual-responsibility groups, learning-groups, and so forth. All of these aimed at decreasing the patients' anxiety by challenging them into social activities and functions. We not only promoted healthy socialization, but also increased the patients' confidence in the doctor so that the short individual interviews became psychotherapeutically effective.

We do not wish to imply that methods which make use of a large staff might not be more effective; but in this particular project we found out that much can be accomplished therapeutically with even a minimum of personnel. Although the results appear encouraging, more of these patients have yet to prove themselves outside the hospital, and only time will tell how much they have really been helped. •

Patients Help Santa Claus

NOT ALL of the 1959 Christmas activities at Traverse City State Hospital in Michigan resulted in gifts for patients. Instead, patients on many of the wards made over 400 dolls, stuffed animals, and other types of toys for needy children. The gifts were constructed from scrap materials donated by lumber companies, department stores, etc., and presented just before Christmas to representatives of six different agencies in the Traverse City area who distributed them to underprivileged children.

The photograph shows members of the agencies inspecting a display of the toys which was set up in the lobby of the administration building. Many of them were of remarkable workmanship, and patients are working on a similar project for this Christmas.

OHMER J. CURTISS
Director, Community Relations

The Brief Case

III. Suing Private and Nonprofit Institutions

IN AN EARLIER ISSUE of MENTAL HOSPITALS, The Brief Case took note of the general rule that patients cannot bring suit for negligence against state mental institutions, but that the U. S. Government has removed the barrier against such suits in cases involving Federal hospitals.

Private institutions operated for profit can, however, be sued under an old and universally accepted rule that an employer ("master") is liable for the negligent acts of his employees ("servants"). *Tate v. McCall 199 S.E. 906 (1938)* is typical. In this case, a nurse advised a patient's wife that someone should be with him at all times, adding that he had escaped from his bed and had been found wandering from his ward. Accordingly, the wife volunteered to sit with him. However, she fell asleep, her husband jumped from a second-story window, and injured himself. In awarding the patient damages for the injuries, the court held that the hospital was obliged to exercise such reasonable care as the patient's condition, which was known to the hospital through its employees, might require. Those in charge of the hospital knew that the patient was, in the court's language, "mentally off." The court classified the wife merely as a "benevolent volunteer," and concluded that the hospital's duty to the patient was not discharged because she was with him.

There has been a tendency on the part of some courts to limit the recovery of damages in negligence cases to situations where the hospital's lay staff has not used reasonable care in attending a patient; thus the hospital is relieved of liability if the acts complained of are "medical" rather than "administrative" in nature.

The difficulty in distinguishing between "medical" and "administrative" acts is illustrated by cases quoted in a recent decision rendered by Judge Fuld of the New York Superior Court: "Placing an improperly capped hot water bottle is administrative (*Iacono v. New York Polyclinic Medical School & Hospital, 296 N. Y. 502*), while keeping a hot water bottle too long on a patient's body is medical *(Sutherland v. New York Polyclinic Medical School & Hospital, 298 N. Y. 682)*. Administering blood by means of a transfusion to the wrong patient is administrative *(Necolsyff v. Genesee Hospital 296 N. Y. 936)*, while administering the wrong blood to the right patient is medical *(Berg v. N. Y. Society of Relief of Crippled, 1, N. Y. 2nd 499, rvg. 86 App. Div. 783)*." In another case, the order of a physician, which sent a mental patient with suicidal tendencies into an X-ray laboratory where he leaped from an unbarred window, was held to be administrative. *Fowler v. Norway Sanatorium et al., 42 N. E. 2nd 451 (1942).*

Commenting on the cases quoted above (and others), Judge Fuld said: "From distinctions such as these, there is to be educed neither guiding principle nor clear delineation of policy; they cannot help but cause confusion, cannot help but create doubt and uncertainty."

In a suit arising in Pennsylvania *(Brown v. Moore 247 F 2nd [1957])* the defendants, owners of a private mental institution, contended that they were not liable for the negligence of the physician employed by the hospital as medical director, that he was hired to perform professional duties but that he was not subject to the control of the hospital. The court, however, held that, while the physician might be regarded as an "independent contractor" in his relationship to the owners, in his relationship to the patient he was in fact an employee of the institution, and the patient could thus recover damages on the basis of the master-servant doctrine. (Generally, those who retain an "independent contractor" to perform services may not be held liable for his acts.)

Originally, charitable institutions, usually church-sponsored, were considered immune from liability. (The church, inspirer of all benevolence, could do no wrong.) This charitable immunity was first declared in this country in 1876 *(McDonald v. Massachusetts General Hospital, 125 Mass. 432)*, and has been justified since then on a number of different grounds, all of which have been severely criticized.

In 1954, for instance, a Kansas court followed the trend expressing the modern attitude of the majority of courts today, when it held in *Noel v. Menninger (267 P. 2nd 934 [1954])*: "Exemption of charitable and nonprofit corporations from liability for their torts is contrary to the Constitutional guarantee of remedy by due process of law to every person for injury done him in person or property." (The courts often use the words, "charitable," "nonprofit," and "eleemosynary" interchangeably.)

Another court which recently abandoned the immunity doctrine said, "Ordinarily, when a court decides to modify or abandon a court-made rule of long standing, it starts out by saying 'the reason for the rule no longer exists.' In this case, it is correct to say that the 'reason' originally given for the rule of immunity never did exist." *(Pierce v. Yakima Valley Memorial Hospital Ass'n. 43 Wash. 2nd 162, 167.)*

On the evidence of the law reports, it seems that there will be an increasing tendency for the courts to regard the hospital psychiatrist as a "servant" of the hospital—even, in some cases, of the state hospital, as well as of the Federal or private hospital. Moreover, the legal right of the patient to sue the very institutions created to meet his specific needs will become increasingly recognized by the courts.

Since unappealed cases do not appear in the law reports, the Brief Case would appreciate information on interesting cases in the unappealed category for comment in this column. Readers' requests for topics for future discussion would also be welcome.

PHYLLIS WOODWARD, LL.B.

By C. P. SEAGER, M.B., B.Ch., D.P.M.
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MENTAL HOSPITALS
And The British National Health Service

ARTICLES DESCRIBING THE NATIONAL HEALTH SERVICE in Great Britain are, in general, written by two classes of physicians. The first group consists of those who were dissatisfied with the Health Service and who escaped by emigration. The second group contains those who accept the advantages as well as the defects of the Health Service and whose descriptions of it tend to have an evangelical fervor.

I do not belong to the first group, and do not intend to fall into the role of lay preacher. But after spending twelve months in the United States, and visiting psychiatric departments and state hospitals in several parts of the country, I would like to present answers to some of the questions I have been asked about the practice of psychiatry under the auspices of the British National Health Service.

INCEPTION OF THE HEALTH SERVICE

The National Health Service came into being in July 1948. Its inception coincided with the end of the period of additional specialist training offered by the Government to the large pool of doctors coming out of the services at the end of World War II.

The war had acted as a great stimulus to British psychiatry. Psychiatrists had emerged from the mental hospitals and entered the officers' quarters. Although they were initially regarded with some suspicion, fear, and mistrust by both medical and lay fellow-officers, their influence did encourage a number of physicians to enter the specialty of psychiatry at the end of the war. A less positive reason why recruitment of physicians for the mental hospitals became easier was the fact that too many had received training in such major specialties as internal medicine. Since there were insufficient senior posts available during the late 1940's many doctors were obliged by economic pressures to enter another specialty. Psychiatry was chosen often because it appeared to be an open field. Many of these new psychiatrists, originally coerced by economic necessity, came to enjoy their work and brought to it an organically-determined approach which may well have had an important bearing on the direction in which British psychiatry is traveling today. Only a minority remain discontented and bitter.

With the Health Service came two significant changes, which played an important part in the subsequent development of psychiatry. The first was the removal of all mental hospitals from the control of local authorities and their placement under the central direction of the Ministry of Health, through Regional Hospital Boards. This meant that the hospitals were no longer dependent on finances available in local areas, or on the sophistication and knowledge of the cities or county councils. This centralization could well have had a leveling-down effect, so that the best became equal to the worst; but in practice, the best hospitals fought to maintain their status, and the hitherto poor hospitals were encouraged to demand finances and facilities to come up to a higher level. This resulted in improvements in staffing, in decoration, and, to a lesser extent, in buildings.

The second change was the Government's official recognition, through its training programs, that psychiatry was a medical specialty on a par with others such as radiology, dermatology, or ophthalmology. There was, therefore, no differential rate of pay between physicians in different specialties, either during their training period or when they assumed positions of responsibility.

There is little doubt but that centralization of hospital control and upgrading of psychiatry as a specialty have played an important part in raising the status of psychiatry and in encouraging recruits to this branch of medicine. Thus it has been considerably easier to implement the changes in outlook, such as the open-door policy, which have been introduced by leaders in modern mental hospital thinking.

STAFF STRUCTURE

The senior staff physicians in the National Health Service are called "consultants." This term is used to denote a rank, and indicates a physician who takes full clinical responsibility for the patient and who frequently

has one or more assistants for whose training he is at least partially responsible. In most hospitals, the medical superintendent and his deputy are consultants. These are administrative appointments made by the Regional Hospital Board which controls hospitals of all types, apart from the teaching hospitals, in its area. As to whether medical or lay administration is the most desirable in the organization of mental hospitals, this question is still unresolved. Until recently the medical superintendent had absolute authority over both patients and staff physicians, which led to difficulties. Now it is accepted that each consultant is fully responsible for the clinical care of his own patients, and it is likely that other arguments will be resolved. It is generally considered that lay administration of the therapeutic community, as the mental hospital is now becoming, is quite unrealistic and unacceptable to the medical profession.

PSYCHIATRIC REGISTRARS

Psychiatrists in training are known as "registrars." There is usually no formal residency program as is found in the United States, but registrars are given training and instruction by the consultant staff and there are usually case conferences, journal clubs, discussion groups, and seminars similar to those found in a U. S. residency program. Didactic lectures are less common, though many university departments organize a formal lecture course of varying duration, usually on a part-time basis. Such a course offers lectures directed toward an examination for the Diploma in Psychological Medicine. This examination is in two parts, the first part being in neuroanatomy, neurophysiology, and psychology; and the second, in neurology and psychiatry. Although the examination is not an official requirement, no registrar could realistically hope to obtain a senior post of any responsibility without having passed both parts of it.

The psychologist plays a somewhat different part in the British mental hospital than he does in the United States. He rarely takes a therapeutic role because his main fields are considered to be research and psychological testing. His training in experimental design and statistical evaluation prompts the psychiatrists to turn to him for advice when planning a research study. Since the roles and fields of action of these two groups are fairly well defined and do not overlap, there is rarely any conflict.

There is a shortage of psychiatrically trained social workers in Britain and, as a result, social work is carried out by personnel trained in other disciplines. Some have been social science students, others nurses, while still others have been trained by the hospital, without having had any previous formal psychiatric or medical background. Since the personality of the social worker is considered more important than formal theoretical knowledge of psychiatric nosology, the shortage of PSW's is not considered a grave handicap.

Occupational therapists receive training in psychiatric knowledge, patient-handling, and in the arts and crafts. Again a shortage of trained therapists has been overcome by the use of untrained assistants who have, in many cases, proved of great value, helping patients by their warm and understanding attitude. While the traditional arts and crafts are still the customary occupation for acutely ill patients in the hospital for a short time, more and more projects are being designed to resocialize the long-stay patients and to rehabilitate them for life outside the mental hospital.

OUR "SISTER" PROFESSION

I have left until last those members of the staff who have the greatest contact with the majority of patients. I refer to the psychiatric nurses. The hospital is divided into wards and each is in charge of a "sister." (The title is a relic of the days when all hospitals were in the care of nursing sisters of religious communities, but now, in most cases, only the title survives.) Ideally the sister has received hospital training both in general nursing and in psychiatry, and she has as her colleagues staff nurses who have usually completed their training in psychiatry. The remainder of her staff will be student nurses undergoing their three-year training course, and assistant nurses who, while receiving some instruction, do not intend to take examinations or proceed to the senior ranks of the nursing hierarchy. Many of the latter are married women who, without the advantage of formal training, have proved themselves capable and worthy participants in the therapeutic community.

I have briefly outlined the staff structure of the typical psychiatric hospital because it lends point to two major differences between British and American psychiatry. These differences, related to each other, are probably unrelated to the National Health Service. Firstly, British psychiatry is hospital-oriented. This means that the majority of psychiatrists receive their training in a mental hospital and continue their work in such a hospital after their training is over. A number of general hospitals also have psychiatric inpatient facilities, but even these tend to be staffed, at least partially, by psychiatrists from a nearby mental hospital.

DOMICILIARY PSYCHIATRY

With few exceptions, this applies also to the day hospitals which are springing up around the country, and to the programs of domiciliary psychiatry. Although emphasis is now directed toward keeping the patient in the community, the typical psychiatrist maintains close contact with a mental hospital.

Domiciliary consultations are an important feature of the National Health Service. The general practitioner is entitled to call upon any consultant in an appropriate specialty to obtain advice concerning diagnosis, treatment, and/or disposition of any of his patients. By a combination of domiciliary visiting and day-hospital treatment, it has been possible to reduce the demands on inpatient mental hospital beds and thus the risk of patients' developing what has been referred to as institutionalization, or institute neurosis.

Partially as a result of this emphasis on the liaison between the general practitioner and the hospital, and also perhaps because a number of physicians came into psychiatry by way of organic medicine, psychotherapy tends

to be supportive and re-educative with emphasis on environmental manipulation, rather than dynamically oriented. It has been suggested that this may have been brought about by the limitation of time, and the large number of patients with which the psychiatrist has to deal as a result of the Health Service requirements. While these may be factors, I think that a number of psychiatrists believe that the results obtained by this type of treatment are equally as good as those produced by dynamically oriented, long-term psychotherapy. There is the added advantage that a considerably larger number of patients can be helped in a given period of time. This is not to say that there is no long-term psychotherapy carried out in Great Britain. On the contrary, there are several active centers, as well as many individual practitioners, in different parts of the country.

FREEDOM OF CHOICE

There is a lot of misunderstanding in the United States about the freedom of patients under the National Health Service to choose their own physicians, and also about the availability of private practice for the psychiatrist. All patients have a choice of family doctor; they are not directed. Equally, the family doctor can accept or refuse a particular patient or family. When the family doctor requires a specialized opinion, he chooses the consultant whom he wishes the patient to see. Most general practitioners are in the Health Service on a whole-time basis, although a few still practice privately. It is estimated that not more than 5 per cent of the population seek private treatment from a general practitioner. On the other hand, many consultants in all the specialties are in part-time practice, devoting a proportion of their time to National Health Service work and the remainder, a definite fraction by arrangement with the Regional Hospital Board, to private work. Many patients, preferring not to join the hurly-burly of the hospital outpatient department, are willing to pay a fee for a private consultation. Fewer are willing to undertake any lengthy treatment or major surgery on a private basis, but can return to this later if they so wish. It is possible, however, for a patient to see a consultant privately and then be referred to a Health Service Hospital for inpatient treatment. The right to practice specialist work privately is jealously maintained by the majority of the medical profession.

There have been many changes in the organization of psychiatric services during the past decade, and it is impossible to know how many of these changes would have occurred had there been no National Health Service. It is probable that changes would have been less uniform throughout the country, since, prior to the incorporation of all mental hospitals under the wing of the Ministry of Health, progress depended mainly on the interest and support of local Visiting Committees.

The Health Service has brought many problems as well as some benefits. It has been said that the general practitioner has become a sorting

clerk, referring cases to one specialist or another and treating none himself, and that he has no time to look after the many neurotic patients who would be on his list. The fact that the family doctor has often had minimal training in dealing with such patients is often forgotten. Improvement in the training of medical students may well remedy this situation, because it is often a feeling of inadequacy rather than a limitation of time which prevents the general practitioner from assuming his responsibilities toward these patients.

There has been developing in Britain a new concept of psychiatric illness. The lay population is becoming accustomed to the idea that mental illness is indeed an illness, and not evidence of moral degradation. This is demonstrated by the high incidence of voluntary admissions, and by the new and liberal Mental Health Act passed by Parliament in 1959, which offers hope of continued improvement in psychiatric services. Psychiatry is slowly becoming accepted as a respectable field of medicine.

The problem of the increasing costs of medical treatment to the individual looms large in modern life. There are many different ways of dealing with the situation, and the National Health Service of Great Britain is one method which has met with some success. It is by no means the only way of dealing with the problem but it is clear that some solutions must be found which appeal to the ideals and way of life of the populace. •

DeWitt's Patients Become Bowlers

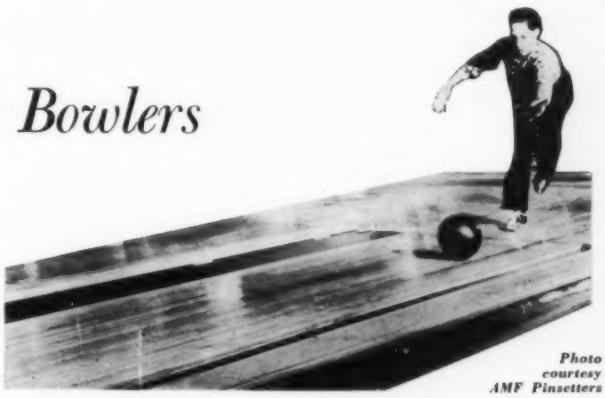

Photo courtesy AMF Pinsetters

BOWLING has recently been added to the outside activities available to the patients at DeWitt State Hospital near Auburn, California. When new bowling lanes were opened in Auburn, DeWitt's superintendent, G. D. Tipton, M.D., arranged with the manager of the alley for patients to bowl at a reduced fee, which is paid from the Patients' Benefit Fund.

Approximately twenty-five patients from several wards in the hospital participate every other week, and the group is accompanied by therapists from the recreation therapy department and by psychiatric technicians. The only requirements are that patients be physically and mentally able to benefit from such an activity outside of the hospital. Participants include young and old men and women, and acute and continued-treatment patients with various mental and emotional problems.

The general plan is for each group of patients to visit the bowling alley three times to permit them to learn the fundamentals of bowling. At the end of six weeks another group begins the cycle. Because of discharges and leaves of absence, patients who have completed the series are frequently scheduled again in later groups. This causes lively exchanges as the one-month veterans tell the newcomers the secrets of the game.

Word of the bowling program spread rapidly among the patients in the hospital and each week many new patients ask to be signed up. Some of the patients have bowled in the past, but this is a brand new experience for most, and the manager of the alley and his wife train each group in the basic bowling form and technique. After the preliminary advice and orientation, the patients and hospital employees are divided into groups of three, and as the bowling progresses, the patients often instruct the employees.

Most of the patients enjoy the game even though they do not expect to become championship bowlers. It provides an enjoyable experience which is not duplicated in therapeutic value by any other activity. The two hours are spent in vigorous action with no time for loafing, personal problems, or case histories.

One young lady who had been hospitalized for many years and had consistently displayed a lack of emotional response suddenly reacted by laughing and shouting when she made a strike. Another critical and hostile patient usually rolled the ball down the gutter and constantly complained, "I just can't do it and there isn't any use trying." Encouragement from other patients and helpful hints about technique soon resulted in a strike for her.

Refreshments contribute to the relaxed and friendly atmosphere, and lively conversations take place over cups of coffee as patients await their turns on the alley. There is a continuous discussion of scores, blunders, and good shots. Patients and employees get to know each other better in the friendly atmosphere and, occasionally, the superintendent comes to observe the activity and coach from the side lines.

The goal of the bowling program is to give the patients an opportunity to gain a lasting interest in an activity which can provide a healthy and wholesome diversion in the future. Patients are being encouraged to use their free time to best advantage, and the enthusiastic comments made by the participating patients indicate that the activity is certainly worthwhile. •

A WORKSHOP For Psychiatric Nursing Assistants

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ALTHOUGH THE PSYCHIATRIC NURSING ASSISTANT is an important member of the hospital team, we find that he is often left out of many of the developmental activities provided for other staff members in the hospital. When he *is* so taken for granted, perhaps because the professional staff is too absorbed in other problems to think about his educational needs, he is, justifiably, apt to feel like just another "fixture."

This realization prompted us to develop a workshop for our nursing assistants at the VA Hospital in Lexington, to further inform them about their part in the care of the psychiatric patient. Although we have many in-service programs for nursing assistants, they usually consist of limited training or refresher courses in such subjects as charting, new drugs, and nursing procedures. While these classes are of definite value and mandatory if the assistants are to succeed in their jobs, they do not meet all of the needs because the groups are seldom large enough to accommodate a broad exchange of ideas and information.

The workshop format seemed to provide an ideal opportunity for a larger gathering which would permit the necessary range of discussion. However, planning the project posed real difficulty, since the hospital operates on a 24-hour day and the needs of the patients must be met. To consider the problems and to formulate tentative plans, a conference was held by the clinical nurse supervisors and the administrative staff. They discussed such items as subject matter, number of nursing assistants that could be spared from each unit, and appropriate times and places for the workshop.

It was agreed that to provide adequate ward coverage during the meetings, the workshop would have to be conducted in two sessions, each lasting for two days. Half of the nursing assistants could attend the first session and the remainder could attend the second session. The only area suitable and large enough for the workshops was a recreation room used by a group of patients, who were willing to relinquish it for the times required.

Subject matter was plentiful, but in outlining the content of the workshop, the conference had to determine what was most needed and what would be most beneficial. The theme, "The Role of the Psychiatric Nursing Assistant," seemed especially appropriate because of current changes and philosophies in the nursing field. Just as the registered nurse's role is changing, so is that of the nonprofessional nursing assistant, and we hoped to bring about better understanding of this change.

The literature in nursing and allied fields did not yield much information but, after searching for appropriate topics and problems, we finally decided that leadership and human relationships were subjects that would support the main theme. In a psychiatric setting, these elements are very important and not always too well understood. If the group could clarify their responsibility in these areas, the workshop could be considered a success.

During the planning stage, the nursing assistant group repeatedly asked: When will it be held? Who will be allowed to attend? What is it going to be like? What are some of the questions? Their interest encouraged us to work that much harder to make it a success.

Various people who were to contribute to the workshop, including the chaplain, manager, chief nurse, chief of psychology, chief of manual arts therapy, and supervisors who were going to act as resource persons, were contacted, and their cooperation eliminated a great many anticipated difficulties.

After the arrangements were final, the program was printed and all materials assembled. The workshop was scheduled to run for a two-day period and then to be repeated one week later for those who could not attend the first time. The hours were 8 a.m. to 4:30 p.m. including recesses and lunch period. The first day of each session the chaplain opened the meeting with an invocation. The remainder of the program was as follows:

FIRST DAY

8:05 Welcome by the Manager.
8:10 Introduction by the Assistant Chief of Nursing Education.
8:15 "What is the Role of the Nursing Assistant?" by the Chief Nurse.
10:00 Group Reports and Discussion.
10:45 Recess.
11:00 Film "Man to Man" and discussion.
12:00 Lunch.
1:00 Role-Playing: "The Patient and the Nursing Assistant."
1:45 Recess.
2:00 Group Buzz Sessions.
3:00 Group Reports and Discussion.
4:00 Summary.

SECOND DAY

8:00 Introduction by the Assistant Chief of Nursing Education.
8:15 Project—Achievement Test—Part I.
9:45 Recess.
10:00 Project—Achievement Test—Part II.
11:30 Discussion Project.
12:00 Lunch.
1:00 "Leadership," by the Chief of Psychology.
1:30 Group Buzz Sessions.
2:30 Group Reports and Discussion.
3:30 Role-Playing: "Top Secret."
4:00 Discussion and Summary.

In the buzz sessions, the participants were given a problem to discuss and asked to plan a possible solution. Each group was limited to six people, who chose a leader and recorder. Resource people who circulated among the groups to assist in any way possible found the activity quite surprising because we had not anticipated such wholehearted involvement, especially since this was a new experience to the group. The reports and discussions afterward were quite prolific; participants had really attempted to work out the problems and had many good suggestions to offer.

Role-playing was not done by the participants this time, because we felt that they might lose some of the benefits that could be derived from observing. However, we expect to develop this technique in future workshops.

The materials, in both the group sessions and role-playing, were all related in some way to the job of the nursing assistant. For example, "Top Secret" dealt with confidential information about the patient, hospital, or personnel. One of the group problems was to give a generalized description of a patient and to devise a plan for nursing care. An occasional personnel problem was presented, because this is all part of the total work climate and must be considered influential in patient care. Such experiences were beneficial in pointing out to the participants some of the strong and weak points in their work habits and their relationships with patients, personnel, and co-workers.

On the morning of the second day, the group was given a two-part project Achievement Test, developed as part of a study conducted by the National League for Nursing. Since a part of the test dealt with psychiatry, we decided to include it in the workshop schedule, and it proved to be a good exercise and an excellent subject for discussion.

At the close of the second day, we asked each group to fill out a brief questionnaire to furnish us some insight into the participants' over-all opinions of the workshop. It was to be answered anonymously to allow for freedom of expression.

RESULTS

The results indicate that the group benefited from the experience. 1. All but three said that this was their first workshop. 2. All felt it had been helpful in some way. 3. The buzz sessions method was rated from good to excellent. 4. The problems were considered of average difficulty. 5. The majority wanted another workshop. The general opinion was that it had helped them to better understand the patient, their own roles, and the need for additional education or inservice training. The open discussions were popular, and the opportunity to talk freely, positively or negatively, was an important factor.

This permissive two-way communication, between the nonprofessional and professional groups, contributed especially to the success of the workshop, because through expressing themselves and offering constructive criticism, the nursing assistants took the first step in their leadership role. Having afforded them this experience during the workshop, we anticipate that they will carry it back to their work areas and apply it.

At the same time, the instructors, supervisors, head nurses, and other staff members learned and benefited from the experience. For instance, we were reminded how very important it is to offer support, reassurance, and trust to our nonprofessional co-workers. The workshop definitely showed the need for the nonprofessional employee to be recognized, and to participate in the various development programs. •

An Activities Group Charts Its Own Course

By CAROLYN OWEN, M.A., O.T.R.
Supervising Therapist, Activities Therapies Department
Illinois Psychiatric Institute, Chicago

How MANY TIMES have you wished that your hospital were not so well steeped in tradition? How often have you thought how much better things would be if you could set the policies and procedures? How frequently have you mumbled that you wish someone would ask you how you thought the treatment program should be implemented?

On July 14 of 1959, the Illinois State Psychiatric Institute opened as a 400-bed hospital with a three-fold purpose: intensive treatment of the mentally ill; training students of all psychiatric disciplines; and extensive research. By July 27, there were two occupational therapists and one recreational therapist on the staff and it seemed as though from that moment on we were asked how *we* saw activity therapies contributing to the total program. Our immediate reaction to this question was, "Don't the other hospital personnel know the value of activity therapies? Are we going to have the age-old problem of interpreting our role to these people here in this newest of all hospitals, with its staff of exceptionally well trained and experienced people?"

ANSWERS AND QUESTIONS

We were somewhat nonplused by this being asked what we thought, and gave some vague and high-sounding answers like, "We want to do intensive treatment; we want to work individually and with small groups of patients, for the most part. We want medical guidance." The replies came back: "What do you mean by intensive treatment? What do you intend to do with patients on an individual or small group basis? What kind of guidance do you need from us?"

This kind of shifting continued throughout the summer, while we enlarged our staff and developed our program along traditional lines. By October, there were three occupational therapists and four recreational therapists. After we had been told repeatedly by the superintendent, the clinical director, and a chief of service, who had been assigned to our department as liaison between us and the medical staff, that neither the medical staff nor the administration was going to set our program for us, we were finally convinced. They said, "You know your skills, your training, your potential. You outline for us what you can do."

One would think we would have been completely delighted at this prospect, and to a certain extent, we were. However, it must be pointed out that this is a very difficult task. It is one thing to complain about what other people do, another thing to alter a policy or procedure that is already set, and still another thing to formulate from the first word a total activity therapies program.

A RARE OPPORTUNITY

We did know that we wished to do this by group process, as we were aware that establishing a totally new department was a rare opportunity, and each of us wanted to be a part of it. We also knew that each of us had something special to contribute and that a program is certain to function most effectively when every staff member has a voice in its formulation.

However, our resistance continued throughout the project, varying in relation to our feelings of adequacy and our courage in facing the task. As an ancillary discipline, we still wondered at our impertinence in defining our own goals without specific direction from a physician.

We began by sitting together as a group and thinking through the various questions before us. We soon decided that eight people were too many, so we split into two groups of four, with therapists of varied training and experience in each group. After three sessions we joined to share our ideas and discovered that our approaches and subjects were quite different. The total group made some more decisions at this time and came up with a new method. We decided that a representative number of people should meet and make recommendations to the total group for its final decision. Thereafter, three of us, an occupational therapist, a recreational therapist, and the supervising therapist, met daily for several weeks, working through various programing problems. Once a week our ideas were presented to the total activities staff for consideration, discussion, and alteration, as the group agreed. In each instance our

final recommended procedures were then presented to the clinical director for his approval.

This method worked well until we recommended a procedure that was totally unacceptable to the administration. They seemed to misunderstand our purposes, and at this point we realized that we were setting up procedures before we had clearly established our goals. Again we found ourselves avoiding the real issue, which was that of defining our role. This was discouraging, but it forced us to focus our attention again on the main issue and recalled us from our wanderings.

The group decided that one person should be responsible for drafting ideas, since the total group could not do this without taking an unreasonable amount of time, which would cut heavily into the many other responsibilities each of us had. At this time I searched the literature to see what had been established and published to date. Among many other things, I learned that definition of role has been a difficult problem for the profession as a whole, and that we were not alone in our plight. However, the references, although not exactly what we needed, were a great help as a structure from which we were able to select the material most suitable for our setting.

The first draft presented to the group was eight pages in length and in paragraph form. A copy was sent to each person for his review and comments. These ranged from minor grammatical changes to major conceptual variations. However, it was very clear that the material was entirely too detailed and not well organized, although the content was generally acceptable. The next step was to determine the major points of emphasis and to elaborate them no more than necessary to illustrate them clearly.

The revised form was distributed to each member of the group. This time the comments varied from complete acceptance to some widely differing points of theory. It was apparent then that group discussion was necessary in order to arrive at common agreement concerning philosophy. Incorporation of the ideas as they stood was impossible. Individual thinking apart from others was no longer of value. The time had come to discuss this thoroughly as a group.

SHADES OF MEANING

We met twice a week for an hour, and took each point one by one, considering it at length. This was very difficult to do. We found ourselves questioning everything, from the use of singular or plural, to how we viewed the psychiatric team and ourselves as members of it. We decided that we wanted an outline form with illustrative examples taken from our daily contact with patients, and we agreed that the selection of words was very important if we were to state our point clearly and with the exact meaning which we intended to convey. The dictionary sat "at our right hand."

This final formulation of our own view of our role was a difficult process, and many reactions were displayed. Some people forgot the meetings; some were late in attendance; others were there, but showed signs of boredom or hostility. We were sometimes angry with one another in our disagreement, other times angry with ourselves and our feelings of inadequacy. We did, however, see much humor in our strivings, and above all, we developed a greater respect for and knowledge of each other. On June 20, 1960, we presented our final statement to the clinical director. To our great pleasure our role as defined by us, (see below) was heartily accepted and approved by the medical staff.

ROLE OF ACTIVITY THERAPIES AT ILLINOIS STATE PSYCHIATRIC INSTITUTE

Professionally trained activity therapists function in the treatment of the psychiatric patient through the use of self, groups, and activities. They contribute their knowledge and skills to the formulation and implementation of treatment goals for each patient by cooperating with the psychiatric team, which is directed by the physician.

The following outline describes various ways in which activity therapists may function:

I. Contribute to the Creation of a Therapeutic Milieu

A. Foster the feeling that living with others can be a safe and satisfying experience.
   Examples: Accepting the patient, his productions, and contributions.

B. Assist the patient in improving his social skills.
   Examples: Planning and participating in group projects and/or activities; chorus; dancing; parties; drama.

C. Encourage socially acceptable interests.
   Examples: Providing opportunities for patients to select and develop areas of interest; instruction in skills.

D. Create an atmosphere in which patients may constructively use their leisure.
   Examples: Supervising evening and week-end recreational programs; supplying books, records, games, etc.

II. Contribute to Patient's Psychodynamic Formulations Through Personality, Social, and Skill Evaluations

A. Through activities, acquire knowledge of the patient which will contribute to a better understanding of his problems.
   Examples: Working with the patient and making significant observations of his responses to staff and patients, his attitudes, skills, interests, and creative productions.

B. Inform the psychiatric team of the patient's moods, relationships, and manner of performance in activity situations.
   Examples: Reporting regularly, in both written and verbal form, significant information concerning patients.

III. Attain Specific Treatment Goals by Supplementing Psychotherapy

A. Provide opportunities for the patient's actual or symbolic gratification of his developmental needs.
   Examples: Preparing and serving refreshments; fingerpainting; using ceramics, papier maché.

B. Assist the patient in establishing healthy dependent-independent relationships.
   Examples: Accepting patient at his level of functioning and adjusting activities to meet prescribed goals.

C. Further the development of the patient's self-concept and assist him to increase his ego strength.
   Examples: Personal grooming; projects for personal use; selective structuring of activities with appropriate limit-setting; encouraging physical fitness and motor-coordination; opportunities for reality testing.

D. Strengthen ego defenses and provide routes for sublimation of aggressive and libidinal impulses.
   Examples: Acceptable means for release of hostility; constructive use of obsessive compulsive behavior; acceptable expression of narcissistic tendencies.

IV. Help Patient Make the Transition from Hospital Life to Community Living

A. Assist patient in evaluating and improving his work potential.
   Examples: Fostering development of effective work habits, useful skills, and a sense of responsibility; providing specific activity assignments.

B. Increase patient's awareness of the community.
   Examples: Inviting community entertainment groups and speakers to the hospital; providing trips into the community; leisure-time counselling.

We look at our efforts with pride and satisfaction, although we know that surely we will continue to revaluate and revise our role as we consider it advisable. We are aware that this covers only our role in relation to intensive treatment. Later we must determine how we can most effectively function in the total training and research programs as well. We know that one of the greatest values of defining our role has been not what this means to other hospital personnel, but what it means to us. We know too that we have only begun by outlining our goals and objectives, that we need to elaborate on each one of these four areas and above all, to put into practice these purposes which we have conceptualized.

SUPPORT FROM THE TOP

We feel that we have grown professionally from this stimulating and demanding experience. (Certainly another complete paper could be written on my own personal growth throughout these months of contemplation, experimentation, and interaction.) We are also aware that none of this could have been possible without the support of the superintendent, the clinical director, and the liaison chief of service, each of whom contributed in his own way.

It is our hope that by sharing this experience and our difficulties with you, we will also have shared our richness of feeling, engendered of professional satisfaction, stimulation, and growth. •

The Language Gateway

SOME TIME AGO we noted that quite a few of the women living in one particular building of this hospital spoke very little or no English at all. Since the hospital operates under a total-push program, any excuse to launch a new activity is readily accepted, the more so if it includes patients not previously reached. Therefore, it wasn't difficult to form groups of these patients, using language as the cohesive factor.

In addition we had three beauticians and one attendant, all first-generation Americans, who were available and willing to become leaders of Polish, Slavonic, German, and Italian groups. Any patient who could speak one of these languages was invited to join the appropriate group. When a group became too large, preference was given to patients who could speak no English at all. Some bilingual patients consistently refused to attend, others dropped out after a few meetings. However, after a few weeks, membership stabilized with both bilingual and monolingual members, and the groups have now been functioning very well for over a year.

Not only are the participating staff members as interested now as they were when the plan began, but, more important, patients within these groups have not isolated themselves from the larger patient population. On the contrary, those who had been withdrawn for many years became more lively when they heard their fellow patients talking about the "old country." At times the groups tended to talk about the hardships experienced there, instead of more pleasant memories. Sometimes the more outgoing patients would come forward with a song or recite poetry in their native language. Although the majority were immigrants, it was apparent that identification with the "old country" or with parental experiences was a dominant and integrating theme.

These patients soon developed a sense of belonging, and it was clear that the language groups fulfilled a real need—the need to communicate. In this respect these patients were starved. They had been isolated not only as a result of their illness but also because of their language barrier. Further, they had been out of contact with their native habits and cultures and the natural manner in which they had been accustomed to expressing grief and happiness.

These people were, in many ways, outsiders even to the hospital. We think that the fact that the leader of the group spoke their language seemed to mean approval in an area where the patient had learned to expect nothing but rejection.

JACOB DE JONG, M.D.
Fairfield (Conn.) State Hospital

REVIEWS & COMMENTARY

READERS' FORUM

Toastmasters Pop Up Again

The following communication was received from the headquarters of Toastmasters International in a letter requesting reprints of the article, "Toastmasters Pop Up at Hospital," which appeared on page 33 of the September issue of MENTAL HOSPITALS.

. . . We are delighted to draw attention to your publication as well as to our interest in making the Gavel Club activity an adjunct to the rehabilitation services provided by mental hospitals.

You may be interested to learn that Mr. Allen W. Grubb, Director of Recreation at Evansville State Hospital, Indiana, has also reported to us the establishment of a Gavel Club which has been successful in helping withdrawn patients and in creating an effective liaison between patients and members of the community.

MAURICE FORLEY
Executive Director

NEW PRODUCTS

Since it is the task of this column to comment on new products, specific note is made below of certain displays shown at the 12th Mental Hospital Institute which are especially pertinent to the needs of psychiatric hospitals. All the exhibitors, both general and pharmaceutical, will be happy to send details about their latest developments and ongoing research. Please be good enough to mention MENTAL HOSPITALS *or the 12th Mental Hospital Institute if you request any information.*

Clothing, Food, and Furnishings:

Karoll's Incorporated drew much attention with a large variety of clothing and furniture. We were very impressed with their E-Z Lounge Mobile, a chair designed to give the patient the utmost in sitting or reclining comfort. This comfortable and versatile chair features a removable dolly which, when attached, makes it possible for a patient to remain in the chair while it is being moved from one location to another. The E-Z Lounge Mobile, complete with the chrome-plated dolly, sells for approximately $65.

In clothing, Karoll's showed a variety of attractive styles in their new Lady Karoll dresses, constructed of a superstrong twill woven into various, over-all small print designs in pastel shades. These dresses have been thoroughly tested and proved to be practical as well as popular with the patients who wore them during the testing period.

Karoll's also came up with the answer to the need for practical yet pretty dresses for those teen and preteen girls who require extra-large sizes. Their Princess Kay dresses, in easy-wear, easy-care styles, are designed to make even the chubbiest girls fit into the popular fashion picture. Again, a strong twill fabric in a small, pastel print is cut for better fashion and better fit. Both the classic shirtwaist and the bateau-bodice styles have an elasticized waist and a shirred skirt, thus eliminating costly and time-consuming alterations while still giving the appearance of personalized fit.

A new idea in Karoll's display was a different adult bib. This bib uses self-closing Velcro instead of the usual flimsy and potentially dangerous drawstring around the neck. Velcro is used again to seal the hem sides to the bib, forming a bottom pocket, which, with just a tug, drops straight for thorough shaking-out and ease of washing. The pocket may be sealed in place again when needed. For information on the above products write to Karoll's Incorporated, Institutional Division, 32 North State Street, Chicago 2, Illinois.

Sharing a booth with Charles Sales Company of Chelsea, Mass., distributors of surplus materials, was State Products, Inc. They were giving samples of their tasty chow mein, about which we wrote after last year's Institute. Here's just a brief reminder that in addition to tasting very good, this dehydrated food formula is easy to store, does not spoil, and can be served for about 7 cents for a 6-ounce serving. For information on all their products, write State Products, Inc. P.O. Box 296, Atlantic City, New Jersey.

Another busy display area was that of Allen Foods, Incorporated, where they served their Lasco Orange Drink. Each four-ounce serving contains 70 milligrams of Vitamin C. In addition to being nutritious, this refreshing beverage is economical and easy to prepare—just add water to the highly concentrated granules. You can write for complete details to Allen Foods, Inc., 4555 Gustine Street, St. Louis, 16, Missouri.

A new exhibitor this year was Desco International Association who featured their Selbatex flooring and their Vitro-Glaze flooring and wall-covering. You might remember that we discussed the Selbatex flooring in this column in April, stating that we were most pleased with a test piece that had been in use for over a year in our institution. A new and decorative feature, adding more interest to this flooring, is the introduction of terrazzo chips into this material. Giving the effect of terrazzo, it is supposed to wear as well, yet costs considerably less and does not present half the installation problems involved with the real thing. For more details write to Desco International Association, Buffalo, New York.

Blue Ridge Textile Co., Inc., another new exhibitor,

showed a variety of items made from their specially constructed nylon fabrics. These fabrics are double-knitted, making both sides of the cloth look the same and making them two to three times stronger than ordinary woven fabrics. Blue Ridge Textile Company calls material of this type the "fabric with a memory" because it can be stretched to the full extreme and completely recover the original size and shape to which it was cut. We have been testing some slips and panties made by this company for the past three months. We can report that they wear like iron and show no signs of wear and tear after more than thirty washings. These garments drip-dry, of course. In addition to women's lingerie, Blue Ridge, Textiles displayed women's dresses, curtains, slippers, and even (using a very heavy denier) knitted nylon upholstery material that has a leatherette appearance. It is worth noting here that during the past 18 months, this company has set up a special division to engineer fabrics to answer specific problems in the mental hospital clothing, drapery, and upholstery needs. For complete information write to Mr. Fred Burnside, Blue Ridge Textile Co., Inc., Bangor, Pennsylvania, or to 112 West 34th Street, New York, New York.

ALEXIS TARUMIANZ

(Other exhibitors included Hollister, Inc., showing an identification system and bed signs, Miles Reproducer Co., Inc., demonstrating a conference recorder, and Twentier's Research, Inc., showing another identification band.)

Pharmaceuticals:

Six of the major pharmaceutical houses—Geigy Pharmaceutical, Roche Laboratories, Sandoz Pharmaceuticals, Schering, Smith Kline and French, and E. R. Squibb and Sons—also exhibited during the Institute, showing their latest advances in the development of new therapeutic agents to meet the demands of modern psychiatry. These attractive exhibits were a vital part of the educational opportunities offered in Salt Lake City, since they enabled a number of physicians to refresh their knowledge of the latest pharmacological therapies.

Geigy Pharmaceuticals featured Tofranil (imipramine hydrochloride), which, while useful in the treatment of depressions, especially in the geriatric patient, is not a monoamine oxidase inhibitor. Roche Laboratories reported recent clinical experiences with the relatively new psychotropic compound, Librium (chlordiazepoxide hydrochloride), which is specifically for the relief of irrational fear, anxiety, and tension. This drug is available in 5, 10, and 25 mg. capsules, the 25 mg. being especially for use in psychiatric hospitals. Among the characteristics of Mellaril (thioridazine hydrochloride), a potent transquilizer shown by Sandoz, the fact that it does not act on the vomiting centers was emphasized. Schering, displaying Trilafon (perphenazine), pointed out that this drug, used for psychotics, is now available in injectible form, as tablets, Repetabs (for prompt and prolonged action), syrup, and concentrate. Smith Kline and French featured Stelazine (trifluoperazine) for the relief of psychotic symptoms. Squibb and Sons described their high-potency phenothiazine, Prolixin (fluphenazine dihydrochloride), said to be effective for many patients refractory to other phenothiazines.

WILLIAM F. SHEELEY, M.D.

FILM REVIEWS

Three English films about psychotic children have recently become available in the United States and are reviewed below. All were made a few years ago at the famed Maudsley Hospital, London, under the direction of E. James Anthony, M.D., who was then at Maudsley's Institute of Psychiatry. Dr. Anthony is now Professor of Child Psychiatry, Washington University, St. Louis, Mo. All three films were made for teaching purposes and are not suitable for showing to the general public. NATURAL HISTORY OF PSYCHOTIC ILLNESS IN CHILDHOOD, the first of the three films revieved below, is being added to the Film Library of the A.P.A. Mental Hospital Service and is expected to be available by Jan. 1. The other two films are distributed by New York University Film Library, 26 Washington Place, New York 3. N. Y.

NATURAL HISTORY OF PSYCHOTIC ILLNESS IN CHILDHOOD (19 minutes, black and white, sound) Produced by the Institute of Psychiatry, Maudsley Hospital, London.

This remarkable film document gives clinicians and students of child psychiatry the opportunity to follow a

case from infancy through to the onset of a psychotic state.

A chain of unusual circumstances made the film possible: first, the child's father was an amateur photographer and took many snapshots and home movies of the child; second, the mother meticulously chronicled the child's early years in a strangely objective diary. As a result, this "natural history" of Margaret's metamorphosis from a happy, precocious toddler of two to a withdrawn, autistic ten-year-old makes an unforgettable film and a valuable teaching aid.

From the family album, with verbal captions from the diary, we learn that Margaret, though a happy, lively baby, is extremely sensitive to noise and is a difficult feeder. Father's movies of his three year-old reveal her intense interest in manipulating things like sticks and buttons. We watch her become less playful, more serious; she spends hours standing about idly. She reacts badly to the birth of a baby brother, has attacks of terror and becomes regressed, rigid, and incoherent of speech. Her pretty little face is devoid of expression, although she is sometimes seized with a primitive type of excitement which makes her flutter like a bird. By this time, the diagnosis is easy to make and she is taken to a residential school where they give her a silver potion at the full moon and make clumsy attempts to "get through" to her. These methods only make her worse, and eventually she is referred to Maudsley Hospital, where the film record continues. She is now a classic textbook example of the psychotic child, wholly self-absorbed, untrainable, responding passively to frustration, and constantly avoiding the world of people.

Although Margaret made a few gains at Maudsley, treatment was abandoned as she approached adolescence. As Dr. Anthony comments in his narration, she is a "Cinderella of psychiatry" for there is no place for her if she does not respond to treatment. There is a final, harrowing glimpse of the child sitting among elderly psychotic women in an adult mental hospital. The pictures alone make this film a fascinating compendium of symptomatic behavior, but it is Dr. Anthony's lucid explanations on the soundtrack that make this a unique teaching aid. In this reviewer's opinion, the film packs far too much of an emotional wallop to be shown to the general public. But for clinicians, medical students, psychiatric nurses, and those who work with emotionally disturbed children its value is unequaled.

CLINICAL ASPECTS OF CHILDHOOD PSYCHOSIS (55 minutes, black and white, silent) and APPROACH TO OBJECTS BY PSYCHOTIC CHILDREN (14 minutes, black and white, silent) Two other films from the series, "The Psychotic Child," produced by the Institute of Psychiatry, Maudsley Hospital.

Viewed as films, these are not as exciting as NATURAL HISTORY OF PSYCHOTIC ILLNESS IN CHILDHOOD. Regarded strictly as "cinematic textbooks," however, they contain much interesting material that would be a valuable complement to the curricula of psychiatric and psychological students. Between the years 1952 (when this special clinic for psychotic children was established at Maudsley) and 1958 (when the film was edited), over 100 children had passed through the clinic. Films were made of each child and, later, were arranged to make a longer film illustrating different syndromes. Despite some gaps, the result is a systematic account of mental illness in children, with the shots grouped under classification, etiology, diagnosis, natural history, symptomatology, differential diagnosis, prognosis, and treatment.

CLINICAL ASPECTS OF CHILDHOOD PSYCHOSIS does a very good job of bringing some order to a somewhat confused clinical picture. APPROACH TO OBJECTS BY PSYCHOTIC CHILDREN limits itself to showing the varying reactions of psychotic children when objects are removed from view. The more autistic children are less able to search for the object or to retrieve it from behind a barrier of glass. When confronted with a mirror image of themselves, autistic children, like normal babies, give little evidence of self-recognition and show more interest in other reflections in the mirror. Both of these films are silent, but contain adequate explanatory titles for each sequence. Instructors who use any one or all three of these useful films on psychotic children will profit from a study of the excellent discussion guides written by Dr. Anthony.

JACK NEHER
Mental Health Materials Center

Snapshots from a family album reveal the progress of psychosis in a child. The gay, precocious toddler of the first picture (left) developed into an anxiety-ridden child who seems to be in perpetual nightmare (center). Only a few years later, her mother said, "The light has gone out in her" (right). From NATURAL HISTORY OF PSYCHOTIC ILLNESS IN CHILDHOOD, reviewed in this issue.

NEWS & NOTES

Program Committee for 13th M.H.I.

Alfred H. Stanton, M.D., McLean Hospital, Belmont, Mass., is the chairman of the Program Committee for the 13th Mental Hospital Institute, to be held October 16-19, 1961, at the Hotel Sheraton-Fontenelle, Omaha, Nebraska. Serving with Dr. Stanton are James E. Gilbert, M.D., Aberdeen, South Dakota; John P. Lambert, M.D., Katonah, N. Y.; John J. Blasko, M.D., Washington, D. C.; and Mr. Joseph Greco, Kansas City, Mo. William F. Sheeley, M.D., of the A.P.A. Central Office, will serve as consultant. The committee will hold its first meeting in Washington, D. C., on December 7 and 8, 1960. Suggestions as to program content, format, and possible speakers will be welcomed, and may be sent to Dr. Stanton at the Central Office of the A.P.A.

Achievement Award Contest

Harold R. Martin, M.D., Rochester, Minn., chairman of the 1961 A.P.A.-M.H.S. Achievement Awards Contest, announces that full details about the upcoming competition will be published in the January issue of MENTAL HOSPITALS. Serving with Dr. Martin are Stewart T. Ginsberg, M.D., Ind., and Hayden H. Donahue, M.D., Ark., with Robert S. Garber, M.D., N. J., as consultant.

The committee has decided that gold, silver, and bronze medallions will be given instead of the silver plaque and honorable mention certificates awarded in previous years.

Hospitals in the U. S. and in Canada are invited to participate, and both public and private hospitals are eligible to compete for an award. Closing date for the contest will be April 1.

A.P.A.-SKF Foundation Awards

At the October meeting of the A.P.A.-Smith Kline and French Foundation Fellowship Committee, four Seymour D. Vestermark Student Grants of $600 were made, one to each of the following: University of Kentucky Medical Center, Georgetown University School of Medicine, University of Washington School of Medicine, and the University of Oklahoma School of Medicine.

A Continuing Lectureship Grant of $2000 was made to the Western State Hospital, Staunton, Virginia, to provide for a psychiatrist from Washington, D. C., to give lectures to all disciplines at the hospital during the year 1961. These lectures will stress new methods of treatment, preparation of patients for aftercare, and other matters dealing directly with the patient.

A grant of $1500 was made to a staff physician at Rusk State Hospital, Texas, for a refresher course at the New York Institute of Psychiatry preparatory to taking the examinations of the American Board of Psychiatry and Neurology. A special grant was given to a psychiatrist from overseas to assist in defraying his expenses while in this country visiting mental hospitals and attending psychiatric meetings.

Business Administrators Elect

At the Second Annual Meeting of the American Society of Mental Hospital Business Administrators, Mr. Joseph Greco of Barnes Hospital, Kansas City, Mo., became the society's second president, succeeding Mr. Alexis Tarumianz of the Delaware State Hospital at Farnhurst, who became chairman of the board. Other officers elected were Mr. A. C. Yopp of the Arkansas State Hospital, Little Rock, president-elect; and Mr. G. W. Brenizer, Jr., Richmond State Hospital, Ind., secretary. Mr. C. P. O'Connell, Middletown State Hospital, N. Y., was re-elected treasurer. Guest speaker at the society's annual dinner was Daniel Blain, M.D., Director of Mental Hygiene for the State of California.

Quarterly Hospital Professional Calendar

A.P.A. ANNUAL MEETINGS:

1961 May 8-12, Hotel Morrison, Chicago, Ill., (117th)
1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 13-17, Ambassador Hotel, Los Angeles, Cal. (119th)

A.P.A. MENTAL HOSPITAL INSTITUTES:

1961 Oct. 16-19, Hotel Sheraton-Fontenelle, Omaha, Neb. (13th)
1962 Sept. 24-27, Hotel Americana, Miami Beach, Fla. (14th)
1963 Cincinnati, Ohio. (Dates & hotel to be confirmed.) (15th)

OTHER PROFESSIONAL ORGANIZATIONS

ACADEMY OF PSYCHOANALYSIS, Mid-Winter Meeting, *December 10-11*, Biltmore Hotel, New York, N. Y .

AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE, Annual Meeting, *December 26-31*, Biltmore & Commodore Hotels, co-headquarters, New York, N. Y.

INTERNATIONAL CONFERENCE OF SOCIAL WORK, *January 8-14*, Rome, Italy. (Inq. Ruth M. Williams, Exec. Officer, 345 E. 46th St., New York 17, N. Y.)

WHITE HOUSE CONFERENCE ON AGING, *January 9-12*, Washington, D. C.

ACADEMY OF RELIGION AND MENTAL HEALTH, Annual Meeting, *January 18-20*, Biltmore Hotel, New York, N. Y.

COUNCIL ON MENTAL HEALTH OF THE A.M.A., Annual Conference of Mental Health Representatives of State Medical Associations, *January 20-21* (New Date) (Inq. Walter Wolman, Ph.D., Acting Secretary, A.M.A. Council on Mental Health, 535 N. Dearborn St., Chicago, Ill.)

NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS, Annual Meeting, *January 23-24*, Safari Hotel, Scottsdale, Phoenix, Ariz.

AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION, Annual Conference, *January 25-28*, Henry Hudson Hotel, New York, N. Y.

WORLD HEALTH ORGANIZATION, 14th Assembly, *February 7*, New Delhi, India.

AMERICAN PSYCHOPATHOLOGICAL ASSOCIATION, Annual Meeting, *February 24-25*. (Inq. Dr. F. A. Freyhan, Secy., 503 Med. Arts Bldg., Wilmington, Del.)

GUILD OF CATHOLIC PSYCHIATRISTS, *Feb. 25-Mar. 1*, Miramar Hotel, Santa Monica, Cal.

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*Abraham, W., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, p. 132.

Literature supplying details of dosage and administration available on request.

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Volunteer Directors Organize

Coordinators and directors of volunteer services on state and hospital levels are in the process of establishing a formal organization under the presidency of Mrs. Miriam Karlins, Coordinator of Volunteer Services for the State of Minnesota. The plan for the new association originated during the meeting held by the volunteer group on October 16 and 17, preceding the 12th Mental Hospital Institute.

Award To Arizona Hospital

The Arizona State Hospital (Samuel Wick, M.D., director) has received the Anniversary Medallion of Merit from the University of Arizona, for "outstanding contribution to the field of medical science and to the State of Arizona through administration of the State Hospital." The award was presented to Dr. Wick and to other recipients on October 12, at the Student Union of the University.

PEOPLE & PLACES

MASSACHUSETTS: **Dr. Sydney Selsenick,** director of professional services at the VA Hospital, West Haven, Conn., has been appointed manager of the VA Hospital at Boston.

Dr. Richard J. Plunkett resigned as secretary of the A.M.A. Council on Mental Health to join the staff of the Veterans Administration Hospital at Brockton.

Dr. Henry Tanner was appointed as manager of the VA Hospital at Northampton, a post left vacant by the death of **Dr. John D. McCullough.**

WEST VIRGINIA: **Dr. Mildred Mitchell-Bateman,** former superintendent of Lakin State Hospital, has been named supervisor of professional services for the Department of Mental Health. **Dr. Kathryn A. Rainbow** was appointed to fill Dr. Mitchell-Bateman's former position.

MARYLAND: **Dr. Lawrence S. Kubie** of Towson, Md., has succeeded the late **Dr. Jacob E. Finesinger** as editor-in-chief of The Journal of Nervous and Mental Disease.

Dr. Russell R. Monroe, formerly of Tulane University, is now professor of psychiatry and director of graduate training at the Psychiatric Institute, University of Maryland in Baltimore.

HERE & THERE: **Dr. Francis J. Braceland,** psychiatrist-in-chief of the Institute of Living, Hartford, Conn., and Past-President of the A.P.A., has been made area editor of The New Catholic Encyclopedia. Dr. Braceland will co-edit the section on psychiatry in the new, 15-volume work that is expected to be completed in 1964.

Dr. E. I. Silk is the new superintendent of Eastern Oregon State Hospital, Pendleton. He succeeds **Dr. Donald Wair** who retired.

Dr. Thomas L. King has been named acting superintendent of Columbus (Ohio) Children's Psychiatric Hospital to replace **Dr. Norman S. Brandes** who has gone into private practice in the Columbus area.

HONORS: **Dr. William Malamud, Jr.,** received the U. S. Army Commendation Medal for meritorious service as psychiatrist at the U. S. Disciplinary Barracks, Fort Leavenworth, Kansas.

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VOLUNTEERS

AUTHORS & SUBJECTS

INDEX TO ADVERTISERS IN MENTAL HOSPITALS FOR 1960

STATEMENT REQUIRED BY THE ACT OF AUGUST 24, 1912. AS AMENDED BY THE ACTS OF MARCH 3, 1933, JULY 2, 1946 AND JUNE 11, 1960 (74 STAT. 208) SHOWING THE OWNERSHIP, MANAGEMENT, AND CIRCULATION OF Mental Hospitals, published monthly at Baltimore, Maryland, (except July and August) for December 1, 1960.

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4. Paragraphs 2 and 3 include, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting; also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner.

5. The average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the 12 months preceding the date shown above was: (This information is required by the act of June 11, 1960 to be included in all statements regardless of frequency of issues.) 11,800. Mathew Ross, M.D., Editor.
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SEAL: Rubina J. Libby
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